MODERNISATION PROGRAMME

BLUEPRINT

Workstream on the Prevention and Treatment of Harmful Alcohol and Drug Use

(Modernisation Programme)
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1. INTRODUCTION

1.1 Mandate

During June 2009 the Provincial government of the Western Cape launched its modernisation strategy aimed at improving its public service institutions to enable it to deliver on its strategic priorities within reasonable time frames. The "modernisation project" as it soon became known was organized into four broad project clusters namely:

1. Legislative Frameworks
2. Organisational Capacity Building
3. Physical Resource Management and
4. e-Government

Each of these Clusters in turn has responsibility for a number of work streams. The Community Support Structures work stream is located within the Organisational Capacity Building project cluster. Whilst most of the Modernisation Workstreams had an intra-government focus; the community support structures has both and internal and external government focus.

The mandate and purpose of this work stream was to draft and develop a blueprint to:

- Design a provincial Prevention of and Treatment for Substance Abuse **strategy** to address harms associated with illegal drug use and alcohol abuse, together with an organisational **framework** for its efficient and sustained implementation. (Note, the term 'substance abuse' in this document denotes the use of intoxicating drugs (including solvents) as well as the abuse of alcohol, prescription medication and over-the counter medication, and broadly includes harmful alcohol or drug use, as well as drug or alcohol addiction.

1.2 Problem statement

Official statistics indicate a sharp increase in substance abuse in the Western Cape over the past 5 years. The full burden of disease, service costs and opportunity costs of harms associated with substance abuse have not been calculated. MRC calculations put the costs of liquor-related violence, drunk driving and other alcohol related injury and illness at around R6 billion per annum in the province (covering medical costs, emergency services, legal services and infrastructure damage) (Parry, 2009). The costs of harms associated with non-alcohol substance abuse (including injury and damage to property due to intoxication, policing operations, processing of cases in the criminal justice system, incarceration, opportunity cost in terms of disinvestment and tourism lost due to drug-linked crime) are also likely to run into billions of Rand.

The strategic importance of addressing harmful alcohol and drug use in the Western Cape is partially illustrated by SAPS statistics showing that the Province has the highest rate of drug-related crime in South Africa (52 000 cases in the 2008/2009 financial year). The ratio per capita is over four times higher than the second nearest Province (1000 per 100 000 in the Western Cape as compared to 235 per 100 000 in KZN), and nearly twice as high in actual numbers. In fact, the Western Cape currently accounts for almost half of all South Africa's drug-related crime on the SAPS records (52 000 out of 117 000 in 2008/2009) – See tables below. The higher figures can also be linked to more effective policing and/or police information management, but the margins are too big to be attributable to this factor alone.

Breakdown of Provincial Drug Related Crime Trends for past 5 years (SAPS)

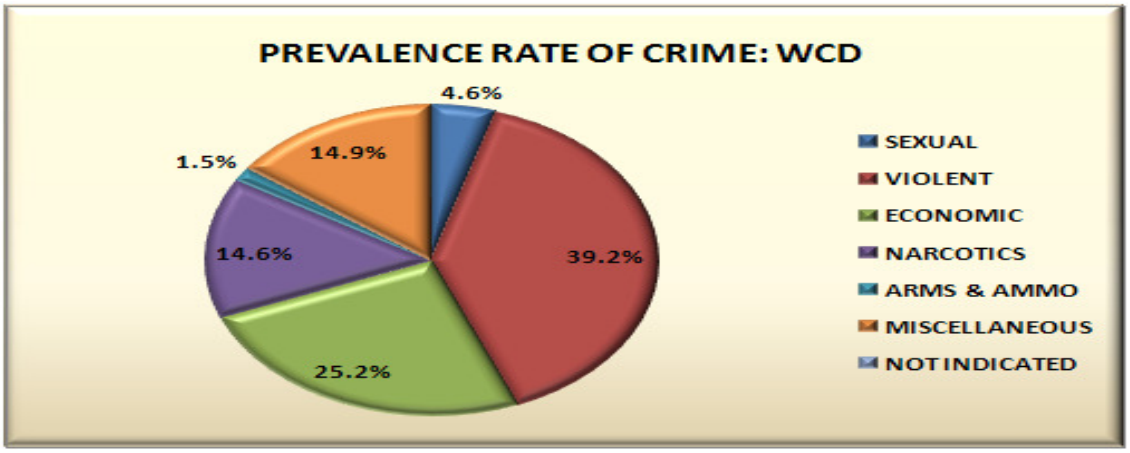
Reported Cases						
Province	2003/2004	2004/2005	2005/2006	2006/2007	2007/2008	2008/2009
Eastern Cape	7,893	9,061	7,511	7,231	8,003	8,437
Free State	3,550	4,063	5,074	5,462	4,525	4,561
Gauteng Province	9,195	10,471	13,753	12,256	12,348	13,338
KwaZulu-Natal	13,599	19,290	23,206	26,228	24,100	23,819
Limpopo	1,706	1,786	1,977	2,178	3,198	3,316
Mpumalanga	1,314	1,714	1,794	2,068	1,770	1,642
North West Province	3,350	4,634	5,502	6,085	7,004	7,345
Northern Cape	2,142	2,550	2,085	2,114	2,201	1,933
Western Cape	19,940	30,432	34,788	41,067	45,985	52,781
RSA	62,689	84,001	95,690	104,689	109,134	117,172

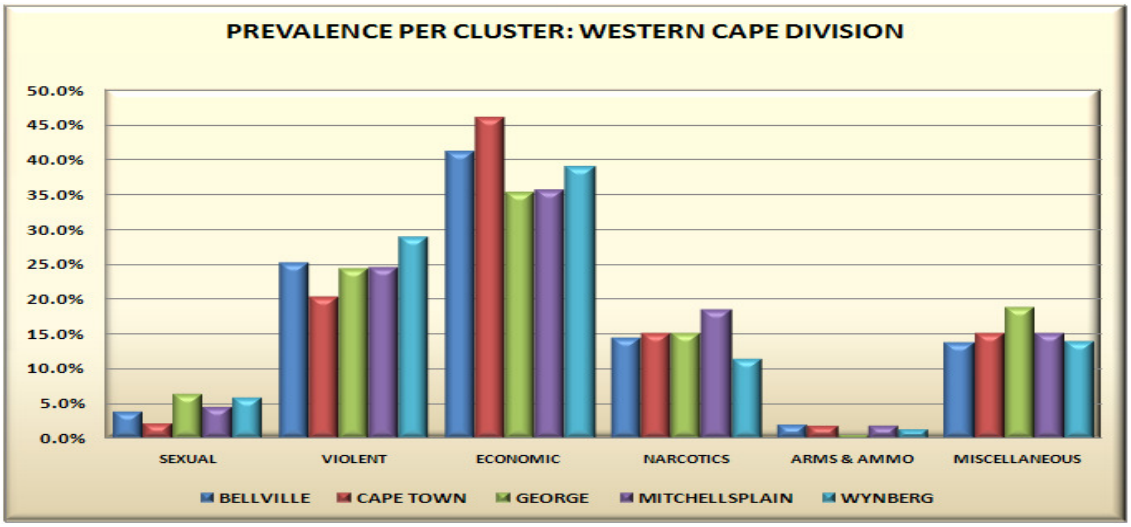
Crime Ratio per 100 000 of the population						
Province	2003/2004	2004/2005	2005/2006	2006/2007	2007/2008	2008/2009
Eastern Cape	114.2	131.4	109.0	104.9	115.9	128.2
Free State	119.6	138.4	171.8	184.6	152.9	158.5
Gauteng Province	101.1	114.1	147.4	128.7	127.5	127.7
KwaZulu-Natal	139.6	197.2	235.7	264.3	240.7	235.7
Limpopo	32.0	33.6	37.0	40.6	59.2	62.9
Mpumalanga	37.8	49.7	51.7	59.0	50.1	45.7
North West Province	100.3	138.2	165.3	180.3	206.4	214.5
Northern Cape	200.8	238.0	193.3	193.1	199.7	171.7
Western Cape	443.2	666.6	749.4	864.8	950.1	1,003.1
RSA	135.1	180.3	204.1	220.9	228.1	240.7

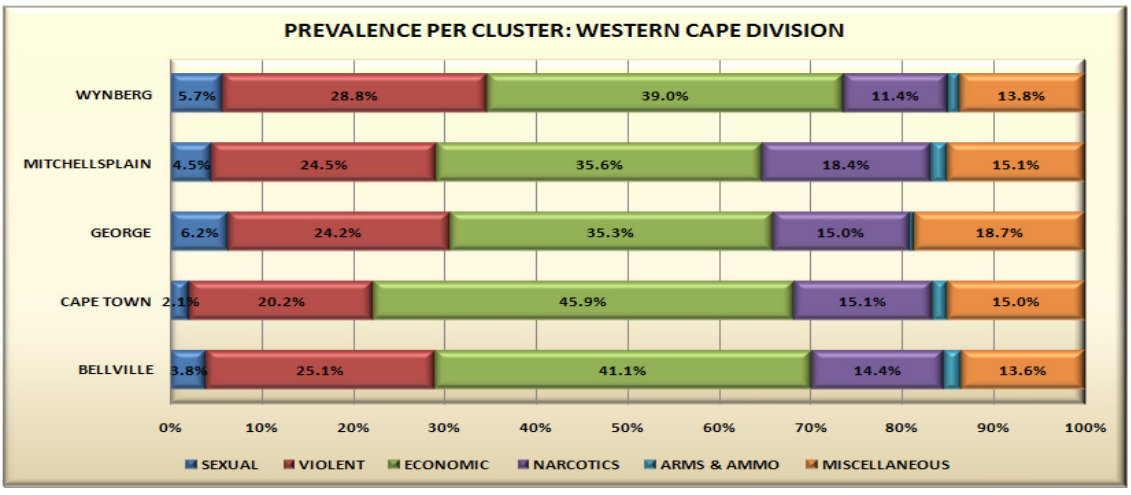
Sample of ten highest rates of drug related crime per Western Cape police station (most recent figures available from SAPS)

SAPS Station	2005/06	2006/2007
MITCHELLS PLAIN	3064	3683
BISHOP LAVIS	1093	1333
ELSIES RIVER	817	1193
CAPE TOWN CENTRAL	1184	1303
PHILLIPI	841	894
KLEINVLEI	634	885
RAVENSMEAD	506	656
KRAAIFONTEIN	568	641
GRASSY PARK	376	586
MILNERTON	370	506

DRUG RELATED CRIME IN THE CONTEXT OF OTHER CRIMES – SAPS FIGURES 2010







Other key findings of recent research:

- Research undertaken between 2002 and 2004 found that the Western Cape had the second highest (7,1%) 12 month prevalence of substance use disorders and the highest (18.5%) lifetime prevalence of substance use disorders. Alcohol is the most frequently abused substance in the province. Across household surveys, the prevalence of lifetime alcohol use in the Western Cape ranges from 39% to 64% and the prevalence of risky drinking or problematic use among drinkers ranges from 9% to 34%. Compared to other provinces, the Western Cape has the highest incidence of risky drinking at 16%. Rural areas appear to have higher rates of binge-drinking than urban areas.
- The province also has the highest lifetime prevalence (70.3%) and highest past 12 month (55.1%) use of alcohol among males. High levels of problem drinking exist among women. For females, the Western Cape had the highest lifetime prevalence (39.2%) and past 12 month use (28.8%) of alcohol. Compared to other provinces, the Western Cape has the second highest prevalence of harmful drinking during pregnancy. The province also has one of the highest rates of Foetal Alcohol Spectrum Disorders (FASD) in the world with 75 out of every 1000 children being affected (Bell, 2009).
- As alcohol has less social taboo status than methamphetamine or other drugs such as dagga, and is thus more socially accepted, it is more widely used by people of all ages. When it (alcohol) is coupled with dysfunctional relationships (particularly family relations), it plays a major role in facilitating crime in the province. Worryingly, youth as young as 9 years old are abusing alcohol. They happen to be both perpetrators and victims. A recent study of drug related crime among youth in Mitchell's Plain has identified the following risk factors for youth substance abuse: family instability, poor relationships with parents and a family history of substance abuse. In so doing it confirms the centrality of the role of the family in socialising its members.
- Alcohol abuse also has a huge impact on the road accident rate and accident fatalities in the Western Cape. It is estimated that, on average, 45% of all accident fatalities involve pedestrians, of whom approximately 60% were under the influence of alcohol when they died on the roads. In Cape Town, approximately half of all driver fatalities tested positive for alcohol (although these fatalities are outnumbered by pedestrian fatalities). During 2007, 0.6% of drivers tested, were charged with driving under the influence of alcohol in the Western Cape. This is 0.4% more than the South African average during 2007.
- The use of methamphetamine (Tik) is escalating. By 2007, the proportion of patients admitted for treatment reporting methamphetamine as primary or secondary substance of abuse had increased to 49%. Treatment data from SACENDU indicate that compared to other provinces, use of methamphetamine as a primary drug of abuse is the highest in the Western Cape (35%) compared to other provinces. This is followed by the Eastern Cape at 5%. Polystimulant abuse is also increasing. For example, methamphetamine is often used in conjunction with other substances such as cocaine. Cannabis and mandrax remain some of the most frequently used illicit drugs in the province. Cocaine is one of the less frequently used illicit drugs, while the use of heroin appears to be on the increase.
- The following graphically illustrates the increase in Tik abuse : in 2002, less than 1% of clients at one of the largest drug treatment centres in the Western Cape, Cape Town Drug Counselling Centre, used Tik; whereas this figure had increased to 52% in 2008 (Health24: 2009). The drug is far more dangerous than any other drug in South Africa, as it makes the user more prone to violence. According to Leggett of the Institute for Security Studies, "methamphetamine is seen as the ideal tonic to prepare gunmen for a hit, removing inhibitions, sharpening senses and fuelling aggression. He draws the further implication that one could expect an intensification of, and increase in violence "among this already violent sector of the population".
- Additional dangers of this drug lie in its attractiveness to non-typical drug users, according to Professor Parry of the Medical Research Council (Government Employees Medical Scheme,

2008). It is also being made popular amongst women who would not normally be taking drugs, but who want to lose weight. The drug's easy availability and ease of manufacturing makes it more accessible to users across the socio-economic spectrum. Its impact is felt in criminal activities committed by the drug abusers to support their habit *(Ajam and Bamford IOL, 2008)*.

- Drug trafficking is in some cases so integrated into community micro-economies that it creates powerful gang structures and gang leaders that exercise enormous power through patronage systems and employment, and are able to circumvent law enforcement efforts. Reliance on the drug trade for income in communities with high prevalence of unemployment makes it extremely difficult to address supply and break criminal networks.
- According to the Medical Research Council (MRC), 98% of Tik addicts who seek help in South Africa come from the Western Cape. The highest user level is found among those who are under 19 years old. The link between Tik use and risky sexual behaviour has been outlined by the MRC. It is reported that Tik users are more likely to have sex whilst under the influence of a substance or substances (alcohol and/or drugs), they are more likely to have multiple sexual partners, they are more likely to have sex at a younger age and they are more likely to trade sex for drugs. Furthermore, it is argued that Tik increases sexual libido, thus putting Tik abusers at risk of contracting sexually transmitted diseases including HIV and Aids.
- Substance abuse therefore poses a major risk of increased child neglect and abuse in the province. It fuels crime and violence, undermines sexual, physical and mental health and has a detrimental economic impact on individuals and households due to the use of scarce resources on substances, rather than on necessities. It further encourages financially reckless behaviour.
- In South Africa a wealth of research is emerging which indicates a strong association between alcohol, drugs, crime and injury. This is confirmed by several community safety audits commissioned by the Department of Community Safety from 2003 – 2007. In this regard attention is drawn to the following:
    - 9,1 % of child sexual offences cases in the Western Cape involved an offender under the influence of alcohol.
    - 67 % of domestic violence in the Western Cape was alcohol related .
    - Among adolescents, alcohol consumption has been found to be associated with both the perpetration of crime and being victimized. It was found that amongst adolescents in Cape Town and Durban that the more frequently they consumed alcohol, the more violent acts they reported to have experienced (Morojele and Brook, 2006).
    - Over 50 % of non natural deaths received at state mortuaries had high levels of blood alcohol concentrations.
    - In 2001, the levels of alcohol positivity for trauma patients in Cape Town injured as a result of violence was 61 %.
    - The incidence of Foetal Alcohol Syndrome (FAS) in Cape Town is I per 282 live births and is regarded as one of the highest in the world.
    - Research conducted by the Department of Transport found that the national daily average of persons driving under the influence of alcohol increased from 1,8 % in 2002, to 2,3 % in 2003 (Arrive Alive, 2005) and that over 60 % of pedestrians involved in collisions were over the legal limit. In the Western Cape, drinking and driving was up from 2,6 % in 2002 to 8,13 % in 2003 especially between 6 and 9 pm.
    - There is a strong correlation between alcohol and drug use and high risk sexual behaviour such as HIV/Aids (Sacendu 2003).
    - Gangs have recently turned their attention to schools in the Western Cape and use learners as their medium for drug sales and the school premises as a place for substance abuse. Almost 63 % of 133 schools reported gang violence and robbery, as the gangs regard schools as a non threatening niche which provides a "captive audience." Two in every five schools reported the presence of drug merchants and peddling.

- During 2009 the SAPS identified the 10 police stations with the highest drug related crime statistics as: *Athlone; Manenberg; Elsies River; Delft; Ravensmead; Kleinvlei; Kuilsriver; Kraaifontein; Mitchells Plain & Phillipi and Cape Town Central.*

1.3 The Business Case and Alignment to Provincial Strategy

As already stated, the burden of disease, crime, opportunity and other costs associated with substance abuse are estimated to run into billions of rand per annum. Addressing substance abuse-related harms supports objectives 1, 2, 3, 4, 5, 8, 9 and 10 of the Provincial Government's 10 Strategic Objectives for 2009 to 2014 (see section 2.4 for details). The Provincial Government also has a legislated role to reduce harms associated with substance use, and to prevent abuse, with education, prevention, treatment and aftercare programmes (inter alia, in terms of the *National Drug Master Plan 2006-2011* and the *Prevention of and Treatment for Substance Abuse Act 2008*). On top of the estimated multi-billion rand burden of disease costs to provincial, local and national government created by drug and alcohol related crime, violence, injury and illness, the Provincial government is currently spending approximately R100m per annum on services that address substance abuse directly. The efficiency and outcomes gained from this use of public funds must therefore be reviewed to ensure that optimum value is added.

1.4 The Scope of the Workstream

The workstream has been revised to produce the following outcomes:

- an integrated provincial **strategy** for prevention of and treatment for substance abuse, with recommendations for Medium Term Expenditure Framework priorities for the lead Departments' budgets and Annual Performance Plans.

- a **framework** for the strategy's implementation – comprising an integrated and transversal management model.

The work stream undertook various activities to achieve this such as :

- Collection and consolidation of information from all three tiers of government and various provincial departments
- Accessing information from national and international research sources and consultations with experts involved in the field of drug and alcohol harm prevention and treatment.
- Co-opting members such as from SAPS and statutory bodies as and when required.
- Preparation of final document
- Revised final document

2. METHODOLOGY

2.1 Project Management

A project management approach linked to the terms of reference (TOR) for the Workstream was used to develop the blueprint.

Project Documentation & Distribution

Project management documentation linked to the TOR for the Substance Abuse Workstream as reflected below:

Author:	Robert Macdonald and Razzaq Lagkar

Project Manager:	Sharon Follentine (first version), Robert Macdonald (revised versions)
Client:	PGWC

Version:	Reference	Date:
Draft b	M.77	09/10/2009

REVISION HISTORY

Version	Date	Summary of Changes	Changes marked
Draft 1	05/10/2009	First draft	N/A
Draft 2	12/10/2009	Second Draft	N/A
Revised version	15/02/2010	Third Draft (split workstream from Community Support Structures workstream)	Entire document revised and rewritten

DISTRIBUTION

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PROJECT NAME	Western Cape Provincial Framework and Strategy for the Prevention of and Treatment for Substance Abuse
CLUSTER LEADER	Linda Grootboom
WORK STREAM LEADER	Robert Macdonald Sharon Follentine
PROJECT TEAM	Robert Macdonald; Debbie van Stade; Zelda Holtzman, Razzaq Lagkar; Jimmy Ledwaba; Sifiso Mbuyisa; Wassiema Hassen;Arthur Cowley; Richard Bosman; Monica Makuala; Zoleka Moon, When the project was reviewed, the following stakeholders were consulted and involved: Dave McNamara (DOSD), Denver Holley (DOSD finance), Sharon Nqadini (DOSD), Dr Ivan Meyer (MEC Social Development), Dr Lynette Rossouw (WCED), Nariman Khan (WCED), Dr Sigamoney Naicker (WCED), Mr Peter Fenton (WCED), Julie Hering (DOSD Western Cape Substance Abuse Forum), Dr Linda Hering (DOH), Dr Liza Weich (DOH), Prof Willie Pienaar (DOH), Carol Dean (DOH), Amanda Brinkman (Strategic Partnerships), Dr Bronwyn Myers (MRC), Dr Ivan Bromfield (COCT Health), Mr Danie Niemand (Department of Agriculture), (Adv. Hishaam Mohamed (DOJ), Provincial Police Commissioner Mzwandile Petros (SAPS), Adv. Lennit Max (MEC Community Safety), Prof Lorna Martin (UCT), Ms Vonita Thompson (DOH forensics), Cllr JP Smith (COCT Mayco Member for Safety and Security), Dr Gilbert Lawrence (Department of Community Safety), Mr Robert Henney (DOJ), Sarah Fisher (COCT consultant), Prof Alan Flisher (UCT Health), Prof Dan Stein (UCT Health), Prof Leslie London (UCT Health), Nasima Badsha (CHEC), Sulaiman Isaacs (Department of Community Safety), Jean Obert (Matrix Institute, UCLA), Donna Johnson (Addiction Solutions, Georgia, USA), Dr Joanne Corrigal (Department of Health), Brent Walters (HOD of Western Cape Department of Cultural Affairs and Sport), Dr Jonathan Lucas, Dr Reyshaad Abdool and Elisabeth Beyer (UNODC), Thurston Smith (USA Federal Government Veterans Health Administration), Leticia Bosch (City of Cape Town Substance Abuse Co-Ordinator), and Raybin Windvogel (Department of Economic Development, Liquor Board)
PROJECTED START DATE	1 August 2009
ESTIMATED COMPLETION DATE	25 February 2010
REVISED VERSION	1 May 2010

2.2 Project Management Structure

The project management structure used for the work-stream has been defined and it is recommended that a similar approach be used for the implementation of the proposals emanating from the blueprint:

Project Management Principles and a Project Management Methodology must be adopted with the implementation of all projects related to the Work Stream.

2.3 Expected Outputs

The expected outputs of the project are

1) A comprehensive strategy for the prevention of and treatment for substance abuse via the PGWC's line functions, and also in partnership with external government and private bodies, which includes clear objectives, targets and timelines.

2) A viable framework for the implementation of the strategy, including:

- a transversal organisational management structure within the provincial government for
    - the mainstreaming of the strategy into line functions of departments
    - the centralisation of the overall co-ordination, monitoring and driving of the project from the office of the Premier, and through a reconstituted Western Cape Substance Abuse forum
- a centralised and standardised IT based information management system for monitoring, evaluating and co-ordinating the implementation of the strategy, including tracking individual cases through the various provincial government and provincial government-funded facilities and programmes, and other outcomes. Baseline studies to be conducted for M&E outcomes to be measured against.
- a structure for co-ordination with other government and non-government bodies relevant to the implementation of the strategy

The overall organisational benefits of the project include the following:

- increased efficiency gains through inter departmental collaboration/value for money
- improved accountability
- promotion of the goals of the IGR Act (seamless government)
- demonstration of integrated project management efficiencies

2.4 Objectives of the Project

Project objective is to support the Provincial Government's ten provisional strategic objectives for 2009 to 2014, namely:

1. Maximising economic and employment growth
2. Improving education outcomes
3. Increasing access to safe and efficient public transport
4. Maximising health outcomes
5. Reducing crime
6. Optimising human settlement integration
7. Maximising sustainable resource management and use
8. Increasing social cohesion
9. Alleviating poverty
10. Clean, value-driven, responsive government

A brief summary follows below of how all objectives with the exception of 6 and 7 are supported:

1) Improving school education outcomes

The 2002 Youth Risk Behaviour Survey reported that 34% of school-going adolescents binge-drink in the Western Cape, which is significantly greater than the national average of 23% (Reddy et al., 2003). The 2008 Youth Risk Behaviour Survey reports that 41% of Western Cape secondary school learners sampled (grades 8-11) had engaged in binge-drinking in the month prior to the survey. The same study found that 24.5% of Western Cape learners sampled had used dagga, of which 16% used dagga on a regular basis, 9% used Methamphetamine, and 10% used Mandrax. On average, 6% used heroine, cocaine or other drugs. Data from the MRC's South African Community Epidemiology Network on Drug Use Project (SACENDU) confirms the challenge that tik poses to young people, with the proportion of persons under the age of 20 in treatment for tik-related problems increased from 4% in 2003 to 57% in the first half of 2007 (SACENDU 2007). Other recent, school-based studies have also identified high levels of MA use among adolescents. For example, Plüddemann et al. (in press) reported that the lifetime prevalence of crystal methamphetamine ("tik") use were 13.3 % and 11.9% for males and females respectively. Males were generally at higher risk than females, although rates are sufficiently high for each gender to justify interventions that universally address all students. Sentinel surveillance of trauma and substance abuse in Cape Town and Durban from 1999 to 2001 revealed that 139 patients younger than 20 years old, were seen at trauma units in state hospitals in Cape Town and Durban during the 1 month study period in each site. Between 1999 and 2001, 31.8% (Cape Town) of adolescents presenting at trauma units had positive breath alcohol levels. Of the trauma patients younger than 20 years of age, 26.9% (Cape Town) tested positive for cannabis. For the 3-year period, 15.4% (Cape Town) of adolescent trauma patients tested positive for Mandrax, 11.5% (Cape Town) tested positive for opiates (such as heroin), and 1.9% (Cape Town) tested positive for cocaine (Parry et al., 2004). The MRC/Institute for Security Studies (ISS) conducted a 3-metro arrestee study of drugs and crime over a three year period. The outcomes of the study indicated, for each phase of the study, arrestees between the ages of 18 and 20 were more likely to test positive for any illicit substance, for cannabis, and for Mandrax than were older arrestees. More recently Tik has increased and possibly surpassed Mandrax in popularity. For phase 1–3, the proportion of arrestees, aged 20 years or younger, testing positive for cocaine increased from 2.3% to 8.7% (Parry et al., 2004).

The study by Townsend et al. (2004) found that there is a correlation between cigarette use and school dropout, although the exact causal relationship is not clear, and there are clearly many other factors that contribute to school dropout. This is consistent with research internationally, which also concludes that there is a correlation between the use of other substances and dropout (Townsend et al., in press). Furthermore, research involving other risk behaviours such as sexual behaviour and involvement in bullying, concludes that these other behaviours also predict dropout. What are not understood are the reasons for the associations: Does the risk behaviour cause the dropout? Do the precursors of dropout, such as absenteeism and other indicators of reduced connection to school, cause the risk behaviours? Or are both caused by other factors such as community or family circumstances? Whatever the reasons for the associations, the fact that there is an association between tobacco use (and other risk behaviours) and substance use and dropout has implications for practice. It is recommended that (i) interventions to reduce the extent of school dropout should include substance use, and interventions to reduce the extent of substance use should include dropout and (ii) interventions should not just address the use of alcohol and illicit drugs but also the use of tobacco among adolescents. Finally, there are associations between substance use and psychopathology. Plüddemann et al. (in press) concluded that "tik" use was associated with poor mental health functioning, aggression and depression (Drugs, alcohol and Schools (MRC, Substance Abuse Trends in the Western Cape, 2008).

- Reducing alcohol and drug use in schools will:
    - reduce disruptions to the learning environment caused by behaviour associated with substance abuse (intoxication and gang activity), improve the learning environment
    - mitigate negative impact of intoxication on individual learners' cognitive, social and other skills development, and improve performance
    - reduce drop-out rates

2) Increasing access to efficient and safe transport

In 2001, the proportion of alcohol positive trauma patients who sustained transport injuries was higher in Cape Town (46%) than in Port Elizabeth (PE) (41%) or Durban (16%) (Plüddemann et al., 2004). In addition, Cape Town was the only site where the proportion of alcohol-positive trauma patients increased significantly from 1999 to 2001. Another study in 2005 showed the proportion of alcohol-positive deaths due to transport injuries was higher in Cape Town (57%) than in Durban (49%), Johannesburg (48%), or Pretoria (49%) (Matzopoulos, 2005).

- Reducing alcohol and drug abuse among drivers and pedestrians can help bring down the rate of vehicle accidents and ensuing trauma.

3) Maximising health outcomes

Apart from transport injuries, findings from the National Injury Mortality Surveillance System reveal that in 2004 the proportion of alcohol positive deaths due to violence was higher in Cape Town (59%) than in Durban (47%), Johannesburg (47%), or Pretoria (51%). Alcohol is strongly related with the risk of becoming a perpetrator and/or victim of violence, and in South Africa violence constitutes the biggest single harm arising from alcohol use (Schneider et al. 2007). It estimated that 300 people in the Western Cape lose their lives due to alcohol use every month and that most of these people are below the age of 40 years (Corrigall, 2010). Most of the disease burden arises from the contribution of alcohol to interpersonal violence (39% of the burden), neuropsychiatric disorders (18%) and road traffic injuries (14%) (Schneider et al. 2007). Encouragingly, evidence indicates that by reducing access to alcohol the number of deaths related to violence and car crashes can be halved. Alcohol use is also strongly associated with sexual risk behaviour in the province. The outcomes of studies conducted on HIV prevalence, substance use and associated high risk practices over the last 7-8 years all echo the same concerns: the need for interventions to address the growing substance abuse problem and its linkage with high risk sexual behaviour (Parry et al., 2008; Shisana et al., 2005). For example, studies conducted by Olley et al. (2005), Kalichman et al. (2006) and Wechsberg et al. (2007) found that rates of condom use and other safe sex practices were lower among persons who used alcohol prior to having sex (Tables 3-4). In addition, Shisana et al (2006) found that hazardous or harmful drinking and binge drinking were related with having more than one regular partner and with having irregular partners. The same applies to tik. For example, Simbayi et al. (2006) found that tik users were (i) more likely to have exchanged sex for money or drugs, (ii) were more likely to have multiple sex partners, and (iii) were more likely to have had unsafe sex while having multiple partners than nonmethamphetamine users. Similarly, Wechsberg et al. (2006) reported that tik users were (i) significantly less likely to have used a condom during the last time they had sex, (ii) significantly less likely to have spoken to their partners about using a condom when having sex, and (iii) more likely to trade sex for tik if they could not afford to by it compared to individuals using drugs other than tik. Parry et al. (2005) also noted inconsistent condom use among tik users. Apart from tik's association with sexual risk behaviour (and the threat this poses to the spread of HIV in the province), tik is also associated with increased risk for mental health problems and violent behaviour. This holds implications for both the health and criminal justice sectors of the province. Plüddemann's (2006) study of tik use among school-going youth found greater risk for depression, anxiety and violent behaviour among tik-using learners than among learners who were using substances other than tik. Parker (2007) also found an association between mental health problems and tik use among a sample of patients in a psychiatric hospital in the Western Cape.

Reducing these harms will:

- Reduce the burden of disease associated with negative physical and psychological effects of alcohol and drug abuse (depression, psychosis, fatal alcohol syndrome, etc.)

- Reduce burden of disease associated with injuries and trauma from violence, vehicle and mechanical accidents associated with drug and alcohol abuse, and other behavioural harms.

4) Reducing crime

A 3-Metro's study on drugs and crime found that compared to other sites, arrestees in Cape Town were more likely to report being under the influence of alcohol at the time of their arrest; with 23%, 16% and 6% of arrestees in Cape Town, Durban and Johannesburg respectively, reporting being intoxicated at the time of the alleged crime for which they were arrested (Parry et al., 2004b). The same study also showed that in 2000, 50.2% of arrestees in Cape Town had lifetime cannabis use and 31.7% lifetime Mandrax use (Parry et al., 2004). The study found that persons arrested for housebreaking and drug and alcohol offenses in particular were more likely to test positive for cannabis and Mandrax (Parry et al., 2004). Studies conducted in the Western Cape have found associations between stimulant use and sexual assault (Kalichman et al., 2004); and crime, especially property crimes (Parry et al., 2004).

- curbing illegal drug use will help cut down crimes associated with drug and alcohol abuse (theft for drug money), and violent crime associated with intoxication (particularly in the case of Alcohol and Methamphetamine). Research also shows that reducing alcohol abuse is particularly important for addressing domestic violence.
- the Provincial Government can assist efforts by the Department of Justice and Constitutional Development to address crime by helping to reduce court backlogs created by criminal cases involving drug users, particularly first time offenders. According to the Department of Justice and Constitutional Development in this Province, court backlogs of up to 30 000 drug related cases per year could be significantly reduced if the Province is able to improve the capacity of its probation services and expand its capacity to accommodate referrals from the courts, and also capacity for diversion programmes that absorb less serious drug use offenders before they even enter the court system (as provided for in national legislation).
- reducing demand for illegal drugs in the long run can weaken the market for these drugs and weaken the associated revenue streams for organized crime (gangs and syndicates). This is particularly important given that the Western Cape is becoming an active node in international crime networks (the Provincial Administration's main contribution in this regard is supporting policing and the criminal justice system).

5) Maximising inclusive economic and employment growth
- Reducing substance abuse and substance abuse related crime (particularly public nuisance, violence, and theft to fund drug and alcohol abuse or addiction) will create a more attractive environment for investors (and tourists). Crime is one of the leading disincentives to investors, and the Western Cape and Cape Town's brands are currently suffering as a result of the high rates of crime and drug abuse.
- Substance abuse programmes, particularly the Matrix model, should ideally be tied to social support networks and skills development programmes, leading recovering persons into gainful employment, community service and other activities that replace drug and alcohol use. Reducing substance abuse in schools will also improve education outcomes, skills development, and the employment prospects of school graduates. It is also an opportunity to strengthen life skills teaching in schools, on farms and in prisons, and to create better catch-net services for youth at risk.

6) Alleviating poverty
- Addressing substance abuse is an important contributor to breaking the cycle of poverty and dependence on state support, in order to open the way for skills development and employment.

9) Increasing social cohesion

- The drug economy, and the behavioural effects of substance abuse, are closely associated with social fragmentation, crime and conflict. Addressing substance abuse and its underlying causes can help remove barriers to social cohesion.

10) Clean, value-driven, efficient, effective and responsive government

- A transversal substance abuse programme and oversight mechanism (including a proper monitoring and evaluation system) will help ensure that all existing state services to address substance abuse are working optimally, and working together efficiently. Stronger information management systems are needed to develop a targeted approach, in order to get the greatest leverage from limited resources (both in terms of geographic need and in terms of the most effective interventions). In addition, outcomes must be measured to assess the ability of all government programmes to produce the desired results, and to allow for effective adjustments of programmes where necessary.
- It will also eliminate duplication or conflict between programmes, and develop integration of services for maximum outcomes. There are currently serious problems with some of the provincial services relating to substance abuse which need to be addressed. These risk damaging the Provincial Government's brand. The same principles apply to the funding of NPO services by the Provincial Government. Rationalising the funding process will avoid duplication and improve monitoring and evaluation, quality control and alignment with strategic objectives.

3. KEY FINDINGS

3.1 General

THE STATUS QUO

After carrying out extensive consultation with Provincial Government Departments, National and Local Government organs, academic organisations, NGO/NPO stakeholders and private sector service providers, the following is a rapid assessment of the current state of services for the prevention of and treatment for substance abuse.

BRIEF OVERVIEW OF THE STATE'S EFFORTS TO ADDRESS SUBSTANCE ABUSE IN THE WESTERN CAPE REGION

In line with the National Drug Master Plan, most government agencies in the Western Cape broadly divide their services into interventions to reduce **drug supply** and interventions to reduce **drug demand**, as well as projects to prevent foetal alcohol syndrome, assist children and learners suffering from foetal alcohol syndrome, and interventions to curb underaged drinking and driving while intoxicated. In addition, the Western Cape Liquor Bill is being developed to strengthen the Provincial Government's control of the retail of and access to alcohol.

In the Provincial Government, the Department of Social Development is the lead department, and runs a Provincial Substance Abuse Forum to co-ordinate services within and outside of the Provincial Administration, loosely in line with the *National Drug Master Plan 2006-2011* (the DOSD also provides a secretariat service to the Forum). Some Departments also have Mini-Substance Abuse Strategies in Place (DOSD, Health, Education). The City of Cape Town also has a Substance Abuse strategy (it is the only municipality in the Western Cape to have done so thus far).

Enforcement interventions against illegal drug and alcohol **supply** (i.e. the production, trafficking, distribution and sale of drugs, and illegal alcohol sales) are mostly under control of the South African Police Services, Metro Police, the Liquor Board, organs of the criminal justice system, border control and related services (see below), as well as Community Police Forums (CPFs) and Local Drug Action Committees (LDACs). The Provincial Government has a legislated oversight and information support role in relation to the work of the SAPS (including CPF support and information management).

The bulk of the Provincial Government's direct competencies to address drug **demand** are divided into 4 main levels of services to the public

Level 1: Awareness and Prevention

Level 2: Screening, Assessment and Brief intervention

Level 3 (a and b): Treatment (in-patient and outpatient – which this document refers to as **levels 3a and 3b** respectively – see appendix for further details)

Level 4: Aftercare

In addition, research training, and information management services are in place. The DOSD co-ordinates its services through 16 District Offices, while the Education Department runs its Specialised Learner Support services through Circuit Teams situated in 8 Education Districts.

[**NB: Please see appendix item on levels of service for more details]**

THE GENERAL CHALLENGES EXPERIENCED: **SUPPLY REDUCTION**

- Sheer scale of the challenge – (SAPS statistics in introduction attest to the scale of drug-related crime). The Western Cape also has approximately 30000 illegal shebeens.
- Arrest rates are high but cases are being delayed or dropped when they enter the court system because of:
    - Sheer number of criminal cases – approximately 30 000 drug related cases on Western Cape court rolls at any given time according to the Department of Justice
    - Unavailability of forensic reports for some cases – forensic reports on substances (mainly for small cases), as well as court testimony by analyst who completed the report if not a member of the public service (or a certified report from a public service analyst in terms of the Criminal Procedures Act), are needed for convictions of dealers to be secured (currently there are about 19 000 samples of drugs in SAPS laboratories that need to be tested and reported on for drug cases, over 5000 blood samples for drunk driving cases and 3200 blood toxicology samples in the National Department of Health Laboratories). The SAPS are taking steps to address this (with over R250 million invested over the past 3 years in the Western Cape and hundreds of new appointments made), but the National Department of Health's strategy is not yet clear (migration of the dysfunctional DOH Forensic Chemistry Laboratory to the more functional National Health Laboratory Service, an entity of the DOH, may be one solution).
    - Delay to or failure of diversion process of small time offenders/youth offenders due to lack of availability of probation officers (specialist Social Workers) in police stations and courts (only 72 probation officers serving the Western Cape Province under the Department of Social Development). The new Child Care Act will increase the need for these services considerably, because it forbids imprisonment of minors.
    - Shortage of skilled professionals in the Western Cape Education Department to address developing substance abuse problems in youth and at schools (49 social workers and 49 school psychologists to serve over 1000 schools – average ratio of 1 social worker and 1 school psychologist to 20 schools, but in some high risk areas the ratio is between 1:40 and 1:57).
    - Ability of wealthy drug dealers to hire skilled legal representatives to delay court cases through technicalities (gang leaders and drug lords in some cases also able to wield other forms of influence to impact cases, such as their standing in the community)
    - Prison system also failing to 'rehabilitate' – instead prisons become 'universities of crime'

- Arrest of perpetrators also hampered by challenges faced by SAPS (including shortages of detectives, high burden of evidence needed, well prepared drug dealers with surveillance systems, new trend of decentralisation of drug retail from specific drug houses to smaller amounts hidden with children and mothers in 'ordinary' households, resulting in the drug trade continuing to grow despite efforts of police
- General shortage of up-to-date research on drug use prevalence
- Weak control of international drug trafficking linkages
- lack of economic alternatives for illegal shebeeners
- difficulties in ensuring trading hours of liquor outlets are adhered to
- lack of community mobilisation against alcohol and its negative impact in communities

THE GENERAL CHALLENGES EXPERIENCED: DEMAND REDUCTION

- poor access to mental health services
- minimal resources for effective alcohol advertisement counter-messaging
- lack of community mobilisation to address alcohol in their communities
- lack of alcohol-free/safe and supervised alternative recreational facilities in areas with high alcohol and drug use (particularly in rural areas, and in the after-school context).
- over-emphasis on in-patient treatment facilities for acutely addicted persons rather than a broader range of services for screening, brief interventions, harm-reduction and outpatient counselling for individuals engaged in harmful drug and alcohol use.
- Overall capacity of state, private and NPO treatment facilities inadequate relative to need, and in some cases funds are inappropriately directed
- Lack of single reliable information source for general public and professionals in the field
- General shortage of up-to-date research on drug use prevalence
- Lack of linking services to ensure seamless services, appropriate referrals, appropriate levels of care (i.e. avoiding treatment 'overkill' or 'under-treatment'). Also lack of adequate preparation and preliminary briefing of patients for treatment, resulting in high drop-out rates.
- Lack of case management to track patients and measure results of treatment
- Lack of enabling regulatory framework for outpatient, prevention, awareness, brief intervention and aftercare services, and for training for these services
- Lack of credentialing system for specialists in the field of prevention and treatment for harmful drug or alcohol use
- Critical lack of specialised and semi-specialised skills within the field. Prevention and treatment for harmful drug and alcohol use is a new discipline which has developed rapidly. South Africa has not kept pace with this. There is a general lack of specialist qualifications and curricula available through existing tertiary education institutions
- Very inconsistent level of service quality within State, NPO and Private sector, and weak monitoring and evaluation of outcomes
- General lack of aftercare services (level 4) to prevent increased state costs of intensive treatment incurred due to repeated relapses of patients
- Inadequate services to target users early in life to prevent development of harmful drug or alcohol use, related behaviours or full-blown addiction. Objectives of 'prevention' initiatives are often unclear or unrealistic.

- Inadequate services in rural areas
- Medications for pharmacological interventions either not on list of Government approved pharmaceuticals and/or not available in South Africa. National and provincial government also need to investigate policy options about opioid substitution treatment – Methadone is currently used in Stikland in-patient facility. More economical and equally effective option is outpatient Methadone Maintenance Therapy, but national policy is not clear on the options available.

WITHIN THE PROVINCIAL ADMINISTRATION

The Provincial Government of the Western Cape spends approximately R100 million per annum on services, projects and programmes to address substance and alcohol abuse related harms across various departments (excluding the much larger, multibillion rand burden of disease and other costs resulting from substance abuse related harms). Some of these are working well. Others have substantial and sound plans in place which are not being fully implemented (or implemented at all). Some lack adequate policy and strategy. Good projects should be supported and expanded, gaps and weaknesses must be addressed.

Key recurring challenges found:

- need for better linkages and co-ordination between departmental initiatives (including between different directorates within departments in the case of Education)
- inadequate information and information management systems on substance abuse trends
- lack of clear monitoring of government project outcomes (including funded NPO projects). There are no baselines or agreed upon units of measurement for outcomes in provincial government projects. Only outputs are measured. Proper monitoring of outcomes will be entirely dependent on sound information management.
- lack of needs analysis to determine gaps and matching of services to need
- almost complete lack of aftercare and reintegration services for people emerging from treatment (see previous section on general challenges related to demand reduction)
- simplistic approach to prevention. Preventing substance abuse requires a comprehensive approach to improving quality of life which includes, inter-alia, after-school programmes for youth who do not have adult supervision during the afternoons (due to absence of parents for whatever reason), skills development and employment opportunities, access to alcohol-free and safe recreation areas, access to pre-school and ECD opportunities, mental health and psycho-social support services, especially to the youth. Correct prevention approaches are critical. The cost of interventions escalates as patients become more severely addicted. The key focus must therefore be on targeted prevention in high-risk areas, and early identification of substance abuse (especially in youth/in schools) and on reducing the progression of the disease. Cost benefit analysis bears this out: average cost of 6 week session of treatment in one of the Provincial Government's in-patient centres is R25 000 per patient (ranges from R18000 to R28000). With an average relapse rate of 60% associated with addiction as an illness, and an estimated return rate in major treatment centres of between 2 and 3 times, the Provincial Government is spending up to R100 000 on individual cases. The downstream cost of not treating such cases may be higher (for example, the cost of administering a major surgical procedure resulting from substance abuse related injury or illness, and also other ongoing subsidies). Prevention initiatives are often not effectively monitored for results (and their objectives also tend to be unclear and unrealistic).
- lack of case management system at facility/operations level
- cost-benefit analyses need to be carried out on all programmes to determine how to achieve maximum benefit from available resources

- Clear policies need to be decided upon up front about how funding is allocated. Currently needs analyses are lacking, and funding allocations are based on available budget and available service providers, rather than based on strategic objectives and defined targets
- some delegations and organisational structures obstruct effective interventions
- national legislation is at times taken for granted in Provincial Departments, even where it may be impinging upon the Provincial Government's quality of services and relative Constitutional autonomy to improve these services (in some cases, Provincial Officials take policy directives from National Government without reference to Provincial executive)

EXISTING PROVINCIAL SERVICES AND FRAMEWORK AT A GLANCE

The table that follows is a department by department breakdown of the projects and services currently offered by the Provincial Government that are directly related to substance abuse (in various ways). Many projects are interdepartmental and co-funded by departments. This is the baseline of the PGWC's current basket of services. Recommendations for adjusting the baseline for improved outcomes follow as part of the Strategy recommendations.

DEPARTMENT OF SOCIAL DEVELOPMENT

Project name	Budget 2009/2010		Outputs	Performance targets (what by when)	Number of staff involved, and staffing issues	Manager responsible for each project
TREATMENT (Level 3b): Inpatient Treatment Services (6 - 12 weeks inpatient services, 24 hour therapeutic care for youth and adults addicted to substances)	De Novo	R15m approx		Approx 800 patients per annum (including court referrals)	This facility has serious management challenges	Province owned
	Kensington	R5m approx		Approx 250 patients per annum		Province owned, privately run
	Ramot	R1m approx		Bed spaces		NPO
	Toevlug	R2.4m approx		Bed spaces		NPO
	Hesketh King	R2.4m approx		Bed spaces	This project needs support to employ more of a multi-disciplinary team. No one with clinical skills on team; only social workers and nursing assistant.	NPO
	TOTAL R 25.5m		1. 1940 adults and youth 2. 2X State free treatment centres 3. State funded NPO treatment centres	1940 patients	*NPO - 54 professionals *Government - 35 professionals	C.Marais Referrals from social workers from DSD, NPO's, private sector and other Departments

TREATMENT (level 3a): Outpatient Specialized Treatment Services	Sultan Bahu	R2.7m approx	Outpatient treatment and other services in 3 centres - Mitchells Plain, Bonteheuwel, Hanover Park			
	Sinethemba	R1.1m approx (with health)	Prototype seamless service centre			
	Cape Town Drug Counselling Centre	R1.5m approx	Outpatient centres in Mitchells Plain and Metro			
	SANCA	R4m approx	Outpatient centres in Metro, George, Knysna			
	TOTAL: R 10.8m		2 - 6 months outpatient intensive treatment services for adults and youth	2798 adults and youth access services.	80 professionals	C. Marais
TREATMENT (level 3a) Pilot Project Outpatient Specialized Treatment services on CHC sites	R 1,7m		2 - 6 months outpatient intensive treatment services for adults and youth	5 health clinics 250 clients per clinic 1250 clients 2010/2011		C. Marais
EARLY INTERVENTION (level 2) Train social workers practitioners in Early Intervention skills	R 604 052		* 100 social workers trained in assessment, brief intervention counselling and referral. *70 Probation Officers + 16 supervisors trained in assessment brief intervention and referral for diversion programs	* 40 Religious leaders *60 Youth leaders * 40 Mosques based lay counsellors		N. Mayosi D. Macnamara
EARLY INTERVENTION (level 2) Pilot Integrated Early Intervention service in faith based sited and MPCC's	R 270 000		Early Intervention service consisting of Awareness, early counselling, support, referral, aftercare	40 churches. 20 mosques. 19 MPCC. 120 Religious leaders. 180 youths. 120 support		N. Mayosi G. Ntshingana

		networks			
EARLY INTERVENTION (level 2) Integrated Early Intervention service on farms addressing HIV/AIDS, Substance Abuse, Domestic Violence	R 803 000	Integrated Early Intervention service on farms consisting of awareness, early counselling and support, aftercare networks and farm worker developmen t, youth prevention program	* 70 farms. * 3 district. * 140 farm lay councillors. * 10 day capacity building program * 500 children * 140 youth	1 + M& E 16 Department of Social Development District Offices	N. Mayosi
EARLY INTERVENTION (level 2) Early Intervention service in ECD sites	R 700 000	ECD sites capacitated to support children with FAS and FASD and parents affected by Substance Abuse	* 200 ECD sites. * 400 practitioners. * 4000 children 0-6 years. * 4000 parents	* 1 M&E * 10 DSD Offices	N. Mayosi
PREVENTION AND AWARENESS (level 1) Capacity Building on New Substance Abuse Act, 2008	R 160 000	Stakeholders Capacity and understandin g enhanced on Treatment for Prevention of Substance Abuse, Act No 70 of 2008	* 120 stakeholders * 10 treatment model papers	* Treatment Models Position papers * 120 Social Workers	N. Ralarala
PREVENTION AND AWARENESS (level 1) Ke Moja Youth Prevention Program	R 3,6m	* 10 Life skills sessions per class group * Alternative activities for youth * Indigenous games and film making	* 10 NPO's * 28 800 youth * 240 schools * 19 MPCC * 7 child and youth facilities	* 44 facilitators * 10 supervisors * 38 youth facilitators	* 40 youth trained in film making N. Ralarala
PREVENTION AND AWARENESS (level 1) Media and Marketing Campaign	R 3m	Awareness messages for different target audiences through radio, newspaper and billboards	* Key messages for parents, youth, service providers * Billboard campaign for 12 months * Print media campaigns for 12 months * Radio campaign 12 months * Media management * All provincial and local radio	Substance Abuse coordinators in 16 Department of Social Development Offices	N. Ralarala

			and print media stations		
RESEARCH Surveillance Systems and Program Indicator Development	R 700 000	Surveillance statistic of all new intakes	* system in 16 DSD offices and 5 NPO's * monthly stats * quarterly analysis	150 - 200 Social Workers	N. Mayosi
GENERAL MANAGEMENT AND CO-ORDINATION Western Cape Substance Abuse Forum (and Local Drug Action Committees)	R1.2m approx				
GENERAL MANAGEMENT AND CO-ORDINATION District Offices			100 social workers and 16 supervisors	social workers employed 16 Department of Social Development District Offices	N. Ralarala
CASE MANAGEMENT Probation Officers	Line budget		72 Probation Officers	Referrals and Diversions from Courts	
GENERAL SUPPORT FOR YOUTH – Places of Safety, Youth Care Centres			70 places of safety		
Total Budget 2009/2010	R 52 m approx				

DEPARTMENT OF HEALTH

Project name	Budget items	Budget amount	Outputs	Number of staff directly involved in project	Manager responsible for each project
TREATMENT (level 3b) Opioid Detox Unit - 10 Beds – Stikland	approximate costs	R 3,133,000.00	Opioid detoxification		Psychiatrist (addictionist) (Prof Pienaar and Dr Weich)
TREATMENT (level 3b) Alcohol Rehab - 30 Beds – Stikland	approximate costs	R 2,685,000.00	Alcohol rehabilitation		Psychiatrist (addictionist) (Prof Pienaar and Dr Weich)
TREATMENT FOR COMMORBID CONDITIONS (level 3b) Psychiatric hospital – Alexander	No separate allocation				Dr Linda Hering
TREATMENT FOR COMMORBID CONDITIONS (level 3b) Psychiatric hospital – Valkenberg	No separate allocation				Dr Linda Hering

PERSONNEL FOR TREATMENT AND OTHER SERVICES (level 3a) Sinethemba – NPO OUTPATIENT, SANCA WC Jointly funded by DoH and DSD	Allocation of approx R400 000-00 plus 2-4 hours consultant psychiatrist time per week will provide estimate cost	Approx R 400 000 plus R 41 114 for consultant time	Comprehensive multidisciplinary team intervention for patients with substance use disorders Leader of team meeting Assessment and treatment of patients with comorbid mental disorders	2 = Registrar weekly, Psychiatrist sessional	DD MHP - at Provincial level, Psychiatrist (Addictionist) District Coordinator
PERSONNEL FOR TREATMENT (level 3a) Cape Town Drug Coinciding Centre - UCT (NPO OUTPATIENT)	Registrar's Time (4-6hrs)	R 32,923.00	Deployment of treatment professional to do assessment and treatment of patients with comorbid mental disorders	1 x Registrar	Don Wilson, Prof Dan Stein
PERSONNEL FOR TREATMENT (level 3a) Sultan Bahu (NPO OUTPATIENT)	4-6 hours consultant psychiatrist time/week	R 61,671.00		1 x Psychiatrist	Psychiatrist (addictionist) (Dr Weich)
PERSONNEL FOR TREATMENT (level 3b) De Novo (DOSD INPATIENT)	2-4 hours registrar time/week	R 32,923.00		1 x Registrar	Psychiatrist (addictionist) (Dr Weich)
PERSONNEL FOR TREATMENT (level 3b) Hesketh King (NPO INPATIENT)	2-4 hours registrar time/week	R 32,923.00		1 x Registrar	Psychiatrist (addictionist) (Dr Weich)
PERSONNEL FOR TREATMENT (level 3b) Toevlug (NPO INPATIENT)	6-9 hours consultant psychiatrist time per month	R 61,671.00		1 x Psychiatrist	Psychiatrist (addictionist) (Dr Weich)
TRAINING Training of health care workers	ongoing - no additional funding				
REGULATION Licensing and Inspections of treatment facilities	Line budget				Zee Brickles
Total		**R 6,040,111.00**			

Department of Education

Project name	Budget	Outputs	Targets	Number of staff directly involved in project	Manager responsible for each project
PREVENTION AND AWARENESS (level 1) Awareness raising and prevention via the Curriculum	Line budget	Learners acquire age- and context appropriate knowledge, skills and behaviour that will protect them	According to the delivery targets of the learning area **Life Orientation**	Information not received	Director: Curriculum

		from drug abuse by way of advocacy, lesson planning and formal tasks / projects			
PREVENTION AND AWARENESS (level 1) Ke Moja (I'm fine without drugs campaign)	Funded by the Department of Social Development and presented in schools	Phase 1 and 2 of Ke Moja	Prevention programme in 70 identified schools	NGO's appointed by DSD to render the services	Director: Department of Social Development
EARLY INTERVENTION (level 2) School searches and drug testing policy	Line Budget	Mediation of the Law	100 schools per annum. Learners and educators will be trained in the policy	Safe Schools Co-ordinators	Safe Schools Manager
PREVENTION Safe Schools Office and Call Centre	Line Budget	Safe Schools Office is essentially a co-ordinating office that assists schools with measures to improve safety on a needs basis. Safe Schools Co-ordinators are stationed in each District Office. The call centre provides online debriefing, support and information to principals, learners, educators and support staff. Safe Schools Call centre will serve as a referral centre to other services (police, treatment, NPOs etc).	Ongoing	Five Safe Schools and Call Centre Consultants	Safe Schools Manager
PREVENTION AND BRIEF INTERVENTION (level 2) School social workers and psychologists				49 qualified social workers, registered with the SA Council for Social Service Professions (SACSSP), working with 49 school psychologists as part of school Circuit Teams EDEN KAROO 7 School social workers and school psychologists	Lynnette Rossouw plus the Western Cape Education Department is divided in eight Education District Offices. Each district office is divided into a number of circuit teams, each headed by a circuit

				DISTRICT METRO NORTH 6 School social workers and school psychologists DISTRICT WEST COAST / WINELANDS 6 School social workers and school psychologists CAPE WINELANDS DISTRICT 6 School social workers and school psychologists DISTRICT: METRO CENTRAL 7 School social workers and school psychologists DISTRICT: METRO SOUTH 7 School social workers and school psychologists DISTRICT: METRO EAST 8 School social workers and school psychologists DISTRICT: BREEDE RIVER /OVERBERG 2 School social workers and school psychologists	team manager and responsible for the learner and educator support of a cluster of schools. The circuit team consists of support personnel (a psychologist, a learning support teacher, an expert on specific disabilities and a social worker), a curriculum specialist, a management specialist and an administrative specialist. Services of, amongst others, a Behaviour Co-ordinator and a Safe Schools Co-ordinator are available.
MANAGEMENT POLICY **Substance Abuse Strategy incorporated into overall Policy Document: *Strategy for Encouraging Positive Behaviour and Responding to Challenging Behaviour in Public Schools 2009*, incorporating a Youth at Risk Model. Other key documents include 'Minimum Standards for Special Education Services for Learners Manifesting, or at risk of Experiencing Emotional and/or Behavioural Difficulties' (Circular 25 of 2006) and guidelines for Drug searches and testing (Distributed via circular in 2009)**		Policies and manuals drawn up to guide schools with learners that have behavioural problems. Creates linkages with Places of Safety (DOSD), Youth Care Centres (Schools of Skills), Special Youth Care Centres (former reform schools) and NPOs.			
FACILITIES **Special Schools**		Schools of Skills, Schools of Industry, Youth Care Centres, Special Youth Care Centres (former reform schools)			

DEPARTMENT OF AGRICULTURE

Project name	Budget	Outputs)	Performance targets	Number of staff directly involved in project	Manager responsible for each project
STRATEGY Strategy for farm workers - under Sub Programme: Farm Worker Development	R300,000-00 for the 2009/2010 financial year out of a total budget R3m for projects under the sub-programme Farm Worker Development (Total sub-programme budget for 2010/2011 is R11.4 million)	A Mini Drug Master Plan in line with the National Drug Master Plan is been completed and will be launched by the Minister of Agriculture in the first quarter of 2010			Mr Danie Niemand: Director for Farm Worker Development
MANAGEMENT, CO-ORDINATION AND RESEARCH – Formation of an Agricultural Substance Abuse Forum		Forum constituted and liaises with the Overall Provincial Substance Abuse Forum and the Department of Social Development			Mr Danie Niemand: Director for Farm Worker Development
EDUCATION AND AWARENESS (level 1) services for farm workers	R250 000 to fund NGOs: Dopstop, Rudnet and Fasfacts				Mr Danie Niemand: Director for Farm Worker Development

DEPARTMENT OF COMMUNITY SAFETY – MOSTLY INFORMATION BASED INTERVENTIONS

Project/task name	Project description	Internal Problems/ Obstacles/	External Problems/ Obstacles/	Proposed Solutions (Strategic Objective)	Resource Requirement	Indicator	Target
		BARRIERS	**BARRIERS**				
SUPPLY REDUCTION **Support to Community Police Forums and Neighbourhood Watches**	Develop Community Support Structures strategy to improve supply reduction at community level through more effective co-		Some CPFs under-resourced and poorly managed. Same applies to neighbourhood watches	Should be linked to Local Drug Action Committees (with CPF chairs sitting on LDACs) to maximise community involvement in grassroots efforts to address drug supply and demand.			

	ordination between police and community (separate modernisation blueprint being developed for this community structures)						
SUPPLY REDUCTION **Oversight of policing of illegal drug trade**	Constitutional and legislative mandate to report on, monitor and evaluate Law Enforcement Agencies performance and compliance to policy.	Oversight role not fully developed and implemented	Lack of agreement with role players wrt accountability	Develop Western Cape legislation for this purpose, and work with SAPS to identify strategic priorities for Province, with focus on drug trafficking, production and retailing Development of internal accountability framework to measure SAPS and Metro Police on Supply reduction DOCS to implement oversight and accountability framework for substance supply reduction Assist Law Enforcement Agencies towards the development of effective Supply Reduction Interventions Accountability framework developed by June 2010 Provide an internal and external M&E framework for an integrated supply reduction strategy			
DEMAND REDUCTION **Traffic Policing – alcohol breath testing of drivers**	Roadblocks, random vehicle checks where drivers are tested for blood alcohol levels by Provincial Traffic police						
FACILITIES **Chrysallis Academy**	Support and skills development programmes for youth with behavioural problems/off						

	endors						
RESEARCH AND STRATEGY to address lack of effective liquor regulation enforcement by Liquor Board	Research, info and analysis on identification of priority areas		Expanding the liquor enforcement units by Liquor Board	Department of Economic Development Liquor Enforcement Unit to be expanded	Evaluate effectiveness of policing iro Supply Reduction interventions Train the CPFs wrt liquor license applications		
RESEARCH AND STRATEGY to address lack of knowledge and information on substance abuse supply	**Information and GIS map of Drug hotspots in the Province (drug dens mapped out)**		Access of information from JCPS cluster		Assessment reports	1	Annually

DEPARTMENT OF ECONOMIC DEVELOPMENT AND TOURISM

Project name	Budget	Outputs	Performance targets	Number of staff directly involved in project	Manager for each project		
STRATEGY: SUPPLY REDUCTION Through enhancement of public participation in the liquor licence application process	R nil (operational costs	1. An information booklet (manual) for public participation in the liquor licence application process 2.		**5**	Raybin Windvogel Director: Liquor Regulation		

		Information sessions with CPFs in the Province on their role in liquor regulation					
STRATEGY: REDUCING LIQUOR-RELATED HARMS Through raising awareness	R1,5m	1. Radio programmes 2. Train, taxi and railway station advertisement campaign 3. Outdoor billboard campaign 4. Support to NGOs and industry associations – FASfacts, Dopstop and ARA	Raising public awareness of liquor-related harms by at least 30% (based on baseline study)	**3**	Manager: Liquor Industry Development, Education and Awareness (to be appointed)		
STRATEGY: REDUCING LIQUOR-RELATED HARMS Through reduction of liquor availability	R 100 000	1. Shorter liquor trading hours 2. Closure of licensed outlets that breach licence conditions 3. A provincial liquor outlet density policy	1. Shorter trading hours imposed in respect of identified classes of liquor licences 2. Disciplinary hearings instituted against liquor outlets in breach of licence conditions within 3 months 3. Density policy adopted by PGWC by year-end	**5**	Raybin Windvogel Director: Liquor Regulation		
STRATEGY: REDUCING LIQUOR-RELATED HARMS Through industry liaison	R nil (normal operational costs only)	Information sessions with industry to improve compliance with law and licence	At least 20 information sessions held (in conjunction with industry associations)	**3**	Manager: Liquor Industry Development, Education and Awareness (to be		

		conditions, and adherence to industry code on responsible trading			appointed)		
STRATEGY: PROVIDING ALTERNATIVES TO SUBSTANCE ABUSE Through skills development		Internship and apprentice-ship programme (NB: Risk of creating perverse incentives must be carefully considered)	1. Design internship/ apprenticeship programme specifically aimed at recovering substance abusers 2. Pilot programme in conjunction with DOSD	**3**	Rahima Logdey Director: Skills Development		

THE FOLLOWING ADDITIONAL PGWC SERVICES ARE ALSO LINKED TO ADDRESSING SUBSTANCE ABUSE:

Transport And Public Works

- The 'SHADOW' war room in partnership with the City of Cape Town and Community Safety, with the inclusion of Drager breathalyser machines. This has proven effective in its pilot phase, and cuts out the need for forensic labs to do testing of blood samples, which is a major source of delays to the finalisation of drunk driving cases.

- Vacant buildings –may be a resource for various services around substance abuse and/or youth care

- EPWP programme, internships and apprenticeships can help with prevention and aftercare (it is an important part of prevention to provide youth in high risk areas with alternative options for time use, and equally important for people who have successfully stopped harmful use of alcohol or drugs).

Department Of Local Government

- Guidelines for the role that local governments can play in addressing substance abuse are set out in the National Drug Master Plan 2006-2011. The Department of Local Government can play a role in helping municipalities to take up their potential functions, particularly in municipal regions where substance abuse is a major problem. Local Drug Action Committees (LDACs) and Municipal Substance Abuse plans are key interventions that Local Governments can drive. LDACs provide a direct linkage between grassroots communities (including local police stations, community organisations and other roleplayers) and the Provincial Substance Abuse forum, and help co-ordinate the distribution of resources. Municipalities also can offer services such as outpatient treatment facilities at municipal clinics, policing support through metro police services, enforce liquor trading hours and zoning, and execute roadblocks with testing of drivers' alcohol levels. The City of Cape Town has implemented all of these interventions.

Department of Cultural Affairs and Sport

- After school activities and sporting programmes that offer alternatives to drug related activities for youth (prevention), and also include life skills components

- Sport and cultural affairs programmes are also linked to recovery programmes, along with skills development and vocational training

KEY GOVERNMENT ROLEPLAYERS EXTERNAL TO THE PROVINCIAL GOVERNMENT WHICH ARE RELEVANT TO THE STRATEGY AND THE FRAMEWORK FOR THE IMPLEMENTATION OF THE STRATEGY (more comprehensive information needed)

Organisations	Services/Programmes	Challenges/Blockages
South African Police Services (policing of drug supply)	arrests of drug offenders social crime prevention projects 'high-flyer' programmes special operations – search and seizure, 252A operations etc. Police intelligence (also NIA) intelligence on gangs and other organised crime linked to drugs	Challenges of co-ordination between different directorates within police Varying levels of co-ordination between Metro Police and SAPS at station level Theft of seized drugs from evidence rooms Infiltration of SAPS by gangs and organised crime in some areas (leads to tip-offs for sting operations and 'loss' of dockets) Manipulation of crime statistics in certain stations Drug use by some SAPS members Lack of skills among junior members of the force (particularly around writing of statements and knowledge of law, will be a major challenge for implementation of the Western Cape Liquor Act) Lack of information and knowledge of options for diversion and referrals of minor and 'small time' drug users in order to facilitate referral to treatment programmes instead of court system.
	SAPS Forensic Laboratories (forensic testing and confirmation of suspected illegal drugs for drug court cases)	Court cases involving '1 tablet cases' or small offences create major burden on SAPS laboratories and clog up court roll. Also a longstanding backlog of around 19 000 outstanding samples in SAPS laboratories that needs to be cleared.
	Support for and co-operation with Community Police Forums and neighbourhood watches	Co-operation and support not consistent across all police stations
Medical Research Council	Research	Small unit, limited financial support

National Council of Social Workers	Regulation and credentialing of social workers.	No specialised credentialing for drug and alcohol treatment and prevention work
Home Affairs	Border control	Poor border control re: illegal and controlled substances
Medicines Control Council	Regulation of pharmaceuticals	Unclear whether sale of precursor chemicals is properly monitored
Marine and Coastal Management	control of perlemoen poaching where this is linked to international trafficking	Inadequate capacity to police coastline effectively
Regional and District courts and judiciary	Court convictions of drug suppliers committals of substance abusers	Huge backlog of cases (approximately 30 000 drug related cases on Western Cape court role at any given time). Results in repeated release and re-arrest of serious offenders, creates extra burden on police. Lack of information and knowledge among some magistrates of options and procedures for referrals and/or diversions of drug users/minors.
Department of Justice, Prosecuting Authorities	prosecutions and/or diversions of offenders	Backlogs as above. Lack of information and knowledge among prosecutors for diversion and alternative sentencing options.
National Department of Health Forensic Laboratories	Urine samples and tissue toxicology for court purposes and other purposes	Backlogs delay court cases and completion of autopsy reports. Current backlogs are approximately 5000 blood samples for drunk driving cases and 3200 blood toxicology samples in the National Department of Health Laboratories in Western Cape.
Local Governments	Traffic police - breathalyser testing for road safety Law Enforcement - enforcement of public nuisance by-laws Planning and Law Enforcement - regulation of zoning regarding liquor sales Law Enforcement - regulation of liquor trading hours Health - awareness, screening and outpatient services in day clinics Health, Social Development, Metro Police - co-ordination of government services with need at grassroots community level via Local Drug Action Committees Metro Police/Law Enforcement narcotics units (including dog units)	Limited equipment and suitably trained staff available to extend breathalyser services massive scale of liquor enforcement for shebeens shortage of skilled professionals to run treatment services lack of awareness of legislated role of local government in addressing substance abuse (only 1 municipality in province has formed LDAC – i.e. City of Cape Town)
National Department of Correctional Services	Imprisonment of offenders, rehabilitation programmes for parolees.	Rehabilitation programmes run by NPOs and Social Development, mostly in pilot phases, not meeting demand
National Department of Social Development	Development of Norms and Standards, Regulations for Legislation, Policy Implementation Guidelines Co-ordination and liaison via Central Drug Authority	Lack of capacity and expertise to create adequate national framework.

KEY NON-GOVERNMENT ROLEPLAYERS EXTERNAL TO THE PROVINCIAL GOVERNMENT WHICH ARE RELEVANT TO THE STRATEGY AND THE FRAMEWORK FOR THE IMPLEMENTATION OF THE STRATEGY

Organisations	Services/Programmes	Challenges/Blockages
Neighbourhood watches and informal community based operation.	Community patrols and 'doorstop' operations/night vigils to undermine localised drug dealing	Lack of resources, based on voluntary efforts, often unsustained, exposes members of public to personal risk
Non Profit (Section 21) organisations providing substance abuse related services (see appendix for full list)	Full range of services (levels 1-4 of demand reduction services in Department of Social Development terminology) Research	Lack of adequate monitoring and evaluation of NPO services procured by state. Poor salaries offered in NPO sector result in skills shortages Variable quality of services and management
Health Professions Council	Credentialing and regulation of treatment professionals	No specialised credentialing for alcohol and drug treatment and prevention professionals. Province is in the process of registering a subspecialty in Addiction psychiatry with HPCSA
The United Nations Office on Drugs and Crime	Proposed partnership being forged for research and co-ordination support to Western Cape Provincial Government, on a pilot project basis, utilising international donor funding	Reliant on National Treasury approval for release of donor funding channelled via UN
International Organisations o Commission for the Accreditation of Rehabilitation Facilities (CARF) o International Credentialing and Reciprocity Consortium (IC&RC)	accreditation of drug treatment programmes credentialing of drug and alcohol treatment and prevention professionals	Not recognised in South Africa
Universities and the Cape Higher Education Consortium	Research and skills development	Lack of specialised training in drug and alcohol treatment and prevention field. Steps being taken to address this, with funding, bursary and fellowship support from PGWC
Companies and other for-profit service providers (see appendix for list of private treatment facilities)	hospitals, psychiatric hospitals, drug treatment centres, individual private practitioners and other service providers	costs can be prohibitive current state policies do not make adequate provision for tapping into this resource delays associated with procurement processes
Support groups – Narcotics Anonymous, Alcoholics Anonymous	Demand reduction level 4 (aftercare recovery and support)	Lack of funding, lack of awareness of organisations among treatment professionals and institutions
Liquor manufacturers		Varying degree of buy-in for increased liquor regulation and responsible advertising, depending on alternative opportunities and effect on profit margin of members

Shebeen Associations		Varying degree of buy-in for increased liquor regulation depending on alternative opportunities and effect on livelihood of members
Religious organisations		Interventions vary
Central Improvement Districts	Business partnerships to clean up crime and grime	

3.2 SHIFTING THE STATUS QUO PART 1 – STRATEGY (OBJECTIVES, TARGETS, OUTCOMES)

STRATEGY BROKEN DOWN INTO 4 STRATEGIC OBJECTIVES (which in turn support the 10 strategic priorities of the Provincial Government's Strategic Plan for 2009-2014)

1) **To reduce the number of citizens experiencing alcohol and drug related harms from the current baseline by implementing improved supply and demand reduction services. ('Harms' include harms to personal wellbeing and the wellbeing of others – some examples are: negative impact on education, negative impact on mental and physical health, unsafe sexual behaviour, increased violent behaviour and so forth).**
2) **To reduce the incidence of Foetal Alcohol Spectrum Disorders by March 2015 by implementing improved prevention strategies.**
3) **To reduce drug and alcohol related crime by means of improved intergovernmental co-ordination between government and criminal justice role-players, improved law enforcement on drinking and driving, improved probation services, improved legislation on liquor trading, and assisting with the elimination of all backlogs in drug related court cases in the Western Cape.**
4) **Objectives 1, 2, and 3 will support the broader strategic goal of reducing the burden of disease and other costs to the state created directly and indirectly by alcohol and other drugs.**

The table below outlines the key steps to be taken in order to realise these strategic objectives (objectives supported by each step listed in left hand column).

TABLE OF TRANSVERSAL STRATEGIC OBJECTIVES AND TARGETS (* = target to be determined once baselines established)

AREA 1: POLICY PRIORITIES FOR DEMAND REDUCTION SERVICES

Policy Priority	Implementing Department/s	Performance Area	Current Performance Levels	Targets					
				2010	2011	2012	2013	2014	2019
Levels 1 and 2: Shift education and awareness programmes, as well as prevention and early intervention initiatives to evidence-based programmes and best practice (including education) **Objectives:** 1) Reduce number of people starting to use alcohol or drugs (and also reduce the progression of alcohol and drug use among those who have already started using) 2) reduce cases of Foetal Alcohol Spectrum Disorders 3) Help equip young people to make informed choices 4) Must dovetail with other services – prevention is generally not effective in isolation from supporting programmes like sports, cultural activities, skills development, job creation and social cohesion projects	All departments	Rationalise information, education, awareness and training projects under one department to ensure consistent messaging and economy of scale.	Publicity, awareness, and training projects currently split across departments. For example, same NPOs working on Fatal Alcohol Syndrome projects funded by Departments of Agriculture, Health, Social Development and Economic Development. Results in weak monitoring and lack of alignment of programmes with policy goals	Shift all funding and management of level 1 projects under Social Development. Can still be run by other departments via DOSD to ensure quality control and economies of scale.	*	*	*	*	*
	Education Health Social Development Agriculture Cultural Affairs and Sport	Single, comprehensive, tested and rigorously researched set of programme content for education and awareness programmes, based on norms and standards for prevention interventions (for future Life Orientation textbooks, extra curricular activities, after school care). Roll out to schools, and other public platforms together with ongoing monitoring and assessment of outcomes. Non-curriculum programmes must be shifted outside of school hours. Must target: Underage drinking and tobacco use Fatal Alcohol Spectrum Disorders (particularly in rural areas – further	Fragmented programmes, weak monitoring and evaluation, and little evidence of success where Monitoring and Evaluation has been carried out. Programmes also do not target parents, which is a major gap in terms of international best practice.	Research and development to identify most effective content, most effective medium or media, and priority districts.	*	*	*	*	*

		research is needed to determine the best possible intervention in this regard)							
	Education	Increase number of suitably qualified social workers available to intervene in schools where psycho-social support is needed – increase capacity to manage learners identified as having substance abuse problem/at risk of developing a problem – including learners who are living in drug/alcohol affected families- The aim is to develop capacity for brief interventions with learners and families at an early stage, before harmful drug or alcohol use develops, and also to give schools extra capacity to execute appropriate referral of learners with drug or serious behavioural problems (this requires a concomitant increase in treatment services for youth) This is also critical for improving academic results in schools – disruptions in the classroom together with the time that Principals and teachers spend dealing with disciplinary matters are reducing time on task in the classroom and time available for the running of the school. Teachers and principals are also not always equipped with the skills needed to address acute behavioural or drug problems.	49 social worker/psychologist pairs serve all schools (over 1000). Average ratio: 1:20 schools, but in some high risk areas ratio as high as 1:40 or 1:57. On average, Department of Education social workers and psychologists can only access each school once per term.	Increase alignment between Social Development 's plan to introduce 49 local service delivery teams and school circuit teams to provide extra support to schools. Begin training of social workers assigned from service delivery teams to engage with schools. Introduce policy to regulate and guide social worker interactions with schools. Basic training in prevention and treatment for harmful drug and alcohol use for existing and new social worker recruits. Review existing	Implement service delivery teams and train delegated member to liaise with local schools	Implement service delivery teams and train delegated member to liaise with local schools	Finalise implementation of service delivery teams and training of delegated member to liaise with local schools	Boost capacity as need is indicated. Basic target should be in the region of 200 social workers assigned to schools between DOSD and WCED – (i.e. 400% increase)	Boost capacity as need is indicated

				institutional arrangement of school social workers.					
	Education; Community Safety to emphasise co-ordination with Social Development and SAPS in all school raids in its annual Police Needs and Priorities Plan	Ensure any school search and testing operations are properly handled to produce positive outcomes (must be managed together with clear policy and plan to deal with offenders – international research shows that school searches and testing can be counterproductive if not managed properly – e.g. can create incentive to drop out or skip school)	SAPS carry out school search operations on month to month basis.	New provincial legislation finalised to regulate school searching and testing.	Communicate new legislative and policy procedures to schools. Ensure alignment between Social Development as above	Ensure alignment between Social Development as above	Ensure alignment between Social Development as above	Ensure alignment between Social Development as above	Ensure alignment between Social Development as above
	Education Cultural Affairs and Sport	Expansion of after-school sport and other programmes, to keep more young people in high-risk areas involved in suitable recreational activities if they do not have other adult supervision during afternoons/school holidays. Aim should be to ensure safe, structured environment is available for as long as possible to each individual. Should incorporate evidence-based education and awareness around substance abuse (as indicated above). Programmes should also be linked to local Social Development service delivery team to ensure psycho-social support is available if problem behaviour manifests among any youth members involved. Programmes should also be accessed for aftercare (Level 4) purposes where appropriate and practical.	Department of Cultural Affairs and Sport is currently in the process of setting up Mass Opportunity Development Centres (from which recreational and life skills programmes will be run after school hours). The Department's target is to have 2 per school circuit within the medium term. These programmes could be expanded in high risk areas, depending on pilot project results.	*	*	*	*	*	*
	Education Community Safety (in capacity support role)	Continue Safe schools interventions – security infrastructure, publicise call centre to schools and parents	Safe schools programme already rolled out. Currently the call centre is accessed for very few drug	Publicise call centre in schools – to learners and parents	Publicise call centre	Publicise call centre, ensure full linkage to Departme	Publicise call centre	Publicise call centre	

			related cases – 180 drug related cases reported in the previous financial year. This reflects only a fraction of cases vis-à-vis the MRC survey results.			nt of Social Development Service Delivery Teams			
		Outcome: Decreased recorded rates of substance abuse in schools	Baseline study needed	Finalise terms of reference for study on overall provincial prevalence with a study that has at least a cohort of 10 000 to 15 000, that is geographically distributed to indicate hotspots by district, and that indicates current rates at which services are accessed. Launch survey.	Receive finalised study. Verify baselines per district in order to guide resource deployment and monitor effectiveness of programmes. Viable targets to be determined once baseline established.	Carry out regular follow-up survey in each district with same terms of reference to measure impact of programmes.	Carry out regular follow-up survey in each district with same terms of reference to measure impact of programmes.	Carry out regular follow-up survey in each district with same terms of reference to measure impact of programmes.	*
		Outcome: Decreased rates of Foetal Alcohol Spectrum Disorders (with focus on educating and treating mothers/parents through community work and interventions among pregnant women in health system and in communities). All screening for FAS risk should also include screening for other substance abuse.	Baseline ranges between 0.5% and 2% of live births in less affected areas, to 7% in severely affected areas.	Assess effectiveness of current programmes. Establish baselines per health District.	*	*	*	*	*
Increase overall provincial capacity for early intervention, out-patient treatment and aftercare (levels 2,3a and 4 as set out in Appendix – measured	Social Development Health	Increase number of spaces available in levels 1, 2, 3a, and 4, as need is identified, to receive patients/referrals/diversion cases/sentenced cases, and ensure spaces are utilised (i.e. that patients are in fact placed in the programmes).	(2800 outpatients) Audit and develop needs analysis for aftercare and recovery services in the Province. These	Improve match between need and services. Determine baselines.	Improve match between need and services. Determine baselines	Improve match between need and services, improve success	Improve match between need and services, improve success	Improve match between need and services, improve success	Improve match between need and

by number of total available spaces per year in duly accredited programmes, and by increased capacity to limit, contain and manage relapse cases in an efficient and increasingly cost-effective manner (also important to help reduce backlogs in courts created by increased arrest rates), and ultimately measured in terms of reduced relapse rates and increased numbers of successfully treated patients **Objectives:** Serves all objectives of strategy by: - treating more people with substance abuse related harms - increasing effectiveness of treatment efforts - ensuring that all services offered by government are complementary and boost each others' effectiveness - increases the range of possible interventions in order to prevent 'overkill' and save resources - increases access to, and effectiveness of		Improve assessment, preparation, motivation etc. so that this scarce resource is reserved for individuals who are likely to engage, work treatment and benefit from it. **Overall intended outcome: Increase rate of successful treatment or appropriate ongoing support/containment for cases that cannot be treated.**	services are severely lacking in our current operations. This should also take into consideration the role of residential youth care centres, which are mostly being moved under the control of Social Development. Provisional analysis indicates need for increase in service levels 1, 2 and 4 (and where increased treatment is needed, the emphasis should fall on out-patient programmes)	Increase budget to fill most critical gaps (especially prevention, brief interventions and aftercare).		rates (see targets below for improvements on baselines)	rates (see targets below for improvements on baselines)	rates (see targets below for improvements on baselines)	service s, improv e success rates (see targets below for improv ements on baselin es)
	Social Development Health	Introduce treatment track centres (see section 3.3.3), with management model for drug assessment and drug intervention teams (measured by Number of treatment track centres)	1 centre that is close to the model (i.e. Sinethemba)	3 (2 new centres in addition to Sinethemba)	*	*	*	*	*
	Social Development Health	Improve provision in medical facilities for patients admitted with acute substance abuse related trauma. Hospitals with high admission rates of patients with acute substance abuse trauma should be incorporated into treatment track clusters, with a small team based permanently or on a rotating basis in the hospital, which can assess, do brief interventions, and refer patients. This should also be extended to other high risk sites where possible (egg. day clinics, etc.)	Departments Of Social Development And Health are planning an integrated substance screening and early intervention service. DSD will fund services for therapists to do proper assessments, early intervention where indicated, motivational	Programme at two hospitals (GF Jooste and one other)	Extend to other hospitals as needed	Extend to other hospitals as needed	Extend to other hospitals as needed	Extend to other hospitals as needed	Extend to other hospita ls as neede d

treatment including provision of continuing care services to limit relapse as far as possible			enhancement and, brief treatment if indicated or referral to appropriate specialized outpatients services where indicated. The plan is to try and introduce 5 sites for the current financial year – collaboration between province and the CoCT – to ensure no overlap but a seamless service. hot spots will be focus, for example GF Jooste hospital						
	Social Development Health	Assistance and training for magistrates, SAPS, NPA, School Social Workers and probation workers for inclusion in regional Drug Assessment and Drug Intervention Teams that will run treatment track centres.	0	Design and implement information campaign (with targeted information packages), followed by training proposals and identification of priority sites	Implement training at priority sites	Refresh training as need is indicated	Refresh training as need is indicated	Refresh training as need is indicated	Refresh training as need is indicated
	Social Development, Economic Development, Cultural Affairs and Sport, Public Works	Develop comprehensive aftercare 'exit point' strategy in conjunction with the Departments of Social Development, Economic Development, Cultural Affairs and Sport, and Public Works, focusing on skills development, alternative activities, apprenticeships etc., as well as system to establish linkages between aftercare and recovery programmes and these		Develop strategy	Implement				

		activities							
	Social Development Health Department of the Premier	Full case management through treatment track for greater number of citizens (success measured by system's implementation, the percentage of case captured on system, and ultimately the number of cases managed through full treatment track to successful recovery)	No comprehensive system	Develop and implement IT based system, with access points at all relevant facilities and DOSD Service Delivery Teams (integrated with province-wide case management system and monitoring and evaluation system)	50% of cases captured. Roll-out of access to all available sites.	100% of cases captured – establish baseline for successful treatment. Roll out of access points to all DOSD service delivery teams.	*	*	*
Match provincial capacity for detoxification and in-patient treatment with need (level 3b) (note: need must be *real* need, i.e. specific need for in-patient treatment. As far as possible and appropriate, outpatient treatment (3a) is a preferable option. Resources for in-patient treatment must also be balanced with other services for less serious cases and prevention, and also with psychiatric services, which are currently inadequate) (measured by number of spaces available per year,	Social Development Health	Ensure appropriate capacity of registered in-patient treatment in province - NPO's providing services need the assistance of senior medical officers, mental health nurses and psychologists with good mental health experience as part of their teams. Current mental health services do not have the capacity to provide for this. Funding allocations needed for this. (Ideally this should also apply to outpatient programs.) Rationalise existing resources, and adopt stricter policy about admissions to in-patient treatment (some assessment must be done as to whether candidate is ready for or needs in-patient treatment, whether out-patient treatment would be more effective, etc.)	Maintain current bed spaces, expand rented bed space in NPO/private facilities where needed. Do cost benefit analysis of outsourcing vs insourcing bed space and NPO vs private sector options. Divide offender patients from non-offender patients (Transform De Novo into centre for offenders only). Re-open Rosendal as Special Youth Care centre for non-offendors with treatment capacity.	Improve match between real need and services. Determine baselines	Improve match between real need and services. Determine baselines	Improve match between real need and services, improve success rates (see targets below for improvements on baselines)	Improve match between real need and services, improve success rates (see targets below for improvements on baselines)	Improve match between real need and services, improve success rates (see targets below for improvements on baselines)	Improved match between real need and services, improve success rates (see targets below for improvements on baselines)
	Health	Ensure appropriate capacity of facilities for co-morbidity (patients with		Improve match	Improve match	Improve match	Improve match	Improve match	Improve

Objectives: Serves all 4 strategic objectives by: - treating more people with substance abuse related harms - increasing effectiveness of treatment efforts - ensuring that all services offered by government are complementary and boost each others' effectiveness - increasing the range of possible interventions in order to prevent 'overkill' and save resources, providing access to effective affordable treatment for those who cannot afford private services		co-occurring mental health problems) (number of beds) to ensure it meets need (within the context of a general need for increased psychiatric and mental health services). Patients with comorbid medical problems (e.g. TB, HIV, STD's, other health problems) are currently incorporated within mainstream healthcare services. Comorbid psychiatric disorders are dealt with in 2 ways, depending on the extent of the problem: 1. Patients with comorbid less disabling mental disorders (e.g. anxiety disorders, mild, moderate depression etc.): treatment for mental disorder via mainstream psychiatric service in a sequential or parallel fashion; dual diagnosis outreach clinics at various NGO rehab programs.; periodic training to substance services on the recognition of these problems and referral pathways within health 2. severe and enduring disabling mental illness (e.g. schizophrenia, disabling bipolar disorder etc.): need for rehabilitation within the psychiatric service, Currently pilot at Stikland to field test such an intervention		between need and services. Determine baselines	between need and services. Determine baselines	between need and services, improve success rates (see targets below for improvements on baselines)	between need and services, improve success rates (see targets below for improvements on baselines)	between need and services, improve success rates (see targets below for improvements on baselines)	match between need and services, improve success rates (see targets below for improvements on baselines)
	Social Development Health Department of the Premier	Include level 3b institutions in case management framework to ensure discharged patients enter step-down care.	Liaison mechanisms to be developed to follow up on discharged patients in stepped down care to ensure their successful placement and	Roll out to further 5 sites	Roll out to 50% of all sites	Roll out to 75% of all sites	Roll out to 100% of all sites	Maintain system	Maintain system

			implement access to global case management database to track progress of discharged patients and pick up repeat admissions						
	AREA 2: POLICY PRIORITIES FOR SUPPLY REDUCTION SERVICES								
Provide support services for substance abuse enforcement **Objective:** supports all 4 strategic objectives by increasing capacity for processing of cases through criminal justice system and reduce backlogs.	Health Department of the Premier	Establish provincial support for forensic laboratories for narcotic substance testing	Province currently provides forensic pathology services.	Get legal opinion, establish preferred model, draw up business plan	Implement service, set target for caseload	Meet target for caseload	Meet target for caseload	Meet target for caseload	Meet target for caseload
	Department of Social Development	Increase number of Probation Officers and assistant probation to carry out diversion of first time/ minor cases of drug users out of the courts and into treatment – (will help reduce court backlogs and free up system to focus on priority crimes – e.g. dealers, violent offendors etc.). Begin with prioritisation of Probation officers assigned to Community Courts	72 Probation officers. NPOs serving to boost this service in certain community and other courts (formerly Nicro and now Kulisa)	Permanent deployment of at least one probation officer to each of the three Community Courts. Redeployment of probation officers to 49 local Service Delivery Teams in terms of Department's modernisation program		Increase to at least 100 probation officers and 100 assistant probation officers as part of Department's recruitment drive (approx. 300% increase)	Continue to increase capacity as and when required		
Reduce alcohol related injuries **Objective:** Supports Strategic objective 4	Department of Community Safety Department of Transport	Increased road blocks	Number of roadblocks (community safety/transport to provide baseline)						

	Community Safety Department of Transport	Increase number of Shadow 'war rooms' with Drager machines and/or blood testing equipment and nurse.	Transport/Community Safety to provide baseline and targets. Clarity to be obtained on admissibility of Drager Machines for drunk driving court cases. Assist National Department of Health forensic Chemistry Laboratories with overtime funding and/or staff to cut backlogs for court cases						
	Economic Development (Liquor Board)	Leverage liquor industry resources to increase visible application of industry codes of conduct relating to responsible trading, safe drinking environments and provision of 'safely home' alternatives		1. Business plan to be devised in conjunction with industry and NGOs for broad-based implementation of industry code and provision of alternative transport options at on-consumption outlets 2. Pilot business plan	Continued roll-out and monitoring (targets to be set in business plan)	Continued roll out and monitoring (targets to be set in business plan)	Continued roll-out and monitoring (targets to be set in business plan)	Continued roll out and monitoring (targets to be set in business plan)	Continued roll-out and monitoring (targets to be set in business plan)
	Economic Development (Liquor Board)	Enforce provisions of new Western Cape Liquor Act, with particular emphasis on consequences for liquor manufacturers that deliver to illegal outlets (proposed R1 million fine for offendors)		Liquor Act to be passed into law.	Ongoing enforcement in partnership with SAPS and municipal law enforcement	Ongoing enforcement in partnership with SAPS and municipal law enforcement	Ongoing enforcement in partnership with SAPS and municipal law enforcement	Ongoing enforcement in partnership with SAPS and municipal law enforcement	Ongoing enforcement in partnership with SAPS and

									municipal law enforcement
	Economic Development (Liquor Board)	Regular reporting on liquor licenses granted, and comparison with SAPS and municipal law enforcement data, ward councillors and CPFs, to establish success rates in terms of reducing trading hours or number of shebeens.		Create sub-committee of Western Cape Substance Abuse Forum for this purpose	Establish baseline and targets for compliance	Ongoing monitoring of compliance and rapid enforcement response	Ongoing monitoring of compliance and rapid enforcement response	Ongoing monitoring of compliance and rapid enforcement response	Ongoing monitoring of compliance and rapid enforcement response
	Economic Development (Liquor Board)	Capacitate Liquor Board to assist Shebeens with migration to regulated, proper business zones, the establishment of safer drinking environments, non service to intoxicated clients, and guidance with economic alternatives		Strategy to be finalised and workshopped with Shebeen associations	Implement and monitor	Implement and monitor	Implement and monitor	Implement and monitor	Implement and monitor
	Community Safety	Emphasise increased SAPS special operations in Annual Police Needs and Priorities Plan and Oversight	Community Safety to provide baseline	Provide annual plan and monitor priorities	Provide annual plan and monitor priorities	Provide annual plan and monitor priorities	Provide annual plan and monitor priorities	Provide annual plan and monitor priorities	Provide annual plan and monitor priorities
	Community Safety	Ongoing liaison, training and assistance for Community Police Forums and Neighbourhood watches, including information regarding LDACs and new Liquor Act	Community Safety to provide baseline						
IMPROVED INTERGOVERNMENTAL CO-OPERATION AND CO-ORDINATION ON SUPPLY REDUCTION									
Provide information on available services and legislative options for magistrates, prosecutors, principals, social workers, psychologists, parents, police and other stakeholders	Department of Social Development	Provide comprehensive directory of all substance abuse service providers by geographical area, together with legal options and processes available for dealing with substance abusers. The product is aimed at adults, and at key stakeholders (eg. Magistrates, Prosecutors, Doctors, Nurses, School Principals etc).		1 Comprehensive guide distributed to all relevant stakeholders		Updated guide distributed		Updated guide distributed	

Training and Assistance for Community Police Forums, neighbourhood watches **Objective:** Supports strategic objectives 1,2,4 and 5.	Community Safety Economic Development and Tourism	Community Safety to support Economic Development and Tourism (Liquor Board) training for CPFs on new liquor legislation	Community Safety to provide plan and targets Training on CPFs role w.r.t. liquor licence applications and monitoring of outlets (licensed and unlicensed)	Participation in liquor licence application process by CPFs	Business plan for training to be completed and implement-tation commenced				
Oversight of SAPS – priority to shut down drug dealing operations **Objective:** Supports strategic objectives 1, 3,4.	Department of the Premier	Investigate Constitutionally compliant special legislation for courts to declare properties where known drug dealing suspects reside and/or multiple drug related arrests have been carried out as suspected drug trafficking points, in terms of which certain types of surveillance and other equipment on the property can be restricted	Legal Services	Monitor compliance Obtain provisional legal opinion on constitutionality of legislation from provincial government internal legal offices. Use as basis for proceeding.					
Oversight of SAPS and municipal law enforcement in closing illegal shebeens (enforcement of Liquor Act and by-laws) – **Objective:** Supports all 4 strategic objectives	Community Safety	Prioritise in SAPS Needs and Priorities Plan and Oversight: enforcement against delivery of alcohol stock to illegal outlets by liquor industry, action against illegal outlets, and viable plan to regulate and migrate existing shebeens into formal business zones	Research needed on baseline and viable targets						
Co-ordination with Departments of Justice and Correctional Services for phasing in of specialised courts **Objective:** Supports all	Department of the Premier Social Development	Align probation and diversion services with three community courts	No fixed alignment	3 Community courts offering probation and diversion services for	As needed	As needed	As needed	As needed	

4 strategic objectives.				less serious offendors					

AREA 3: POLICY PRIORITIES FOR BUILDING ORGANISATIONAL CAPACITY AND CAPACITY OF NON-GOVERNMENT SECTOR

Increase management and human resource capacity in substance abuse services field (measured by number of credentialed prevention and treatment of harmful drug and alcohol use professionals in Province) **Objective:** Supports all 4 strategic objectives by building a registered and duly trained workforce in an under-resourced field to provide all tiers of interventions (i.e. members for drug assessment and drug intervention teams, across the spectrum, for Department of Health, Social Development, Education, Community Safety, Department of Justice, SAPS, and Department of Correctional Services.	Social Development Health Department of the Premier	Introduce set of internationally recognized curricula and qualifications for substance abuse workers at varying levels of specialisation in partnership with regional Universities. Course should be registered with SAQA and NQF, and open to all health and social welfare professionals. Use modules of course as training for existing social worker and other provincial government staff (with opportunity to work toward full qualification). Modules can also be used for specialisation in other post-graduate course like Social Work and Psychology. Recruit graduates as needed, and utilise learnership opportunities.	Only qualifications for clinical psychiatrists and non-specialised qualifications for social workers and social auxiliary workers (MPhil at UCT and SUN)	Design and implement a postgraduate diploma in substance abuse services at Western Cape Universities, in partnership with the Cape Higher Education Consortium, Fund bursaries and link to posts in PGWC. Fund appointment of course convenor, lecturers, and cost of curriculum development	Implement course, with 10 – 15 students Use modules to train relevant provincial staff as needed	Implement course, with 10 – 15 students Use modules to train relevant provincial staff as needed	Implement course, with 10 – 15 students Use modules to train relevant provincial staff as needed	Implement course, with 10 – 15 students Use modules to train relevant provincial staff as needed	Implement course, with 10 – 15 students Use modules to train relevant provincial staff as needed
	Social Development Health Department of the Premier	Facilitate the establishment of an independent credentialing authority for professionals working in the field of substance abuse, regulated by the industry (not government) and aligned with IC&RC		Facilitate establishment of independent professional credentialing authority	Support as needed. Introduce funding policy that requires NPOs to have credentialed service providers				

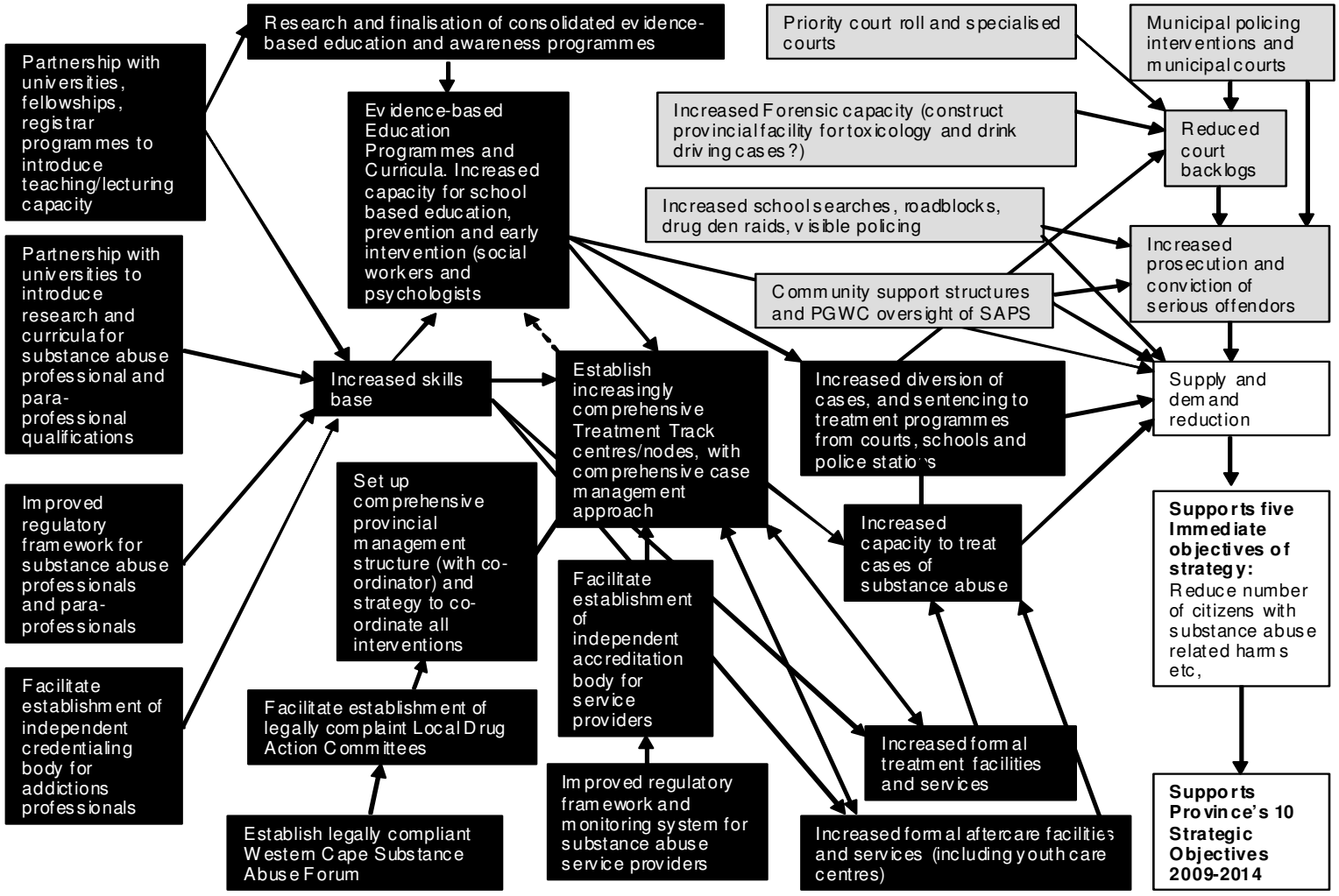
					in order to receive grant funding in the field of substance abuse (see below)				
	Social Development Health Department of the Premier	Increase number of qualified practitioners for all tiers of intervention Comment: this is in the context of a general shortage of qualified medical and paramedical professionals. Can also involve training of existing nurses, psychologists, OT's in the treatment of substance disorders. Staff specifically require appropriate training in evidence based models. Focus on specific skills in the sites where integrated models are provided (i.e. training must be co-ordinated and prioritized in relation to areas earmarked for integrated service centres).	Level 1: Social Development to provide baseline	Department of Social Development to develop feasible targets within its overall strategy to boost its internal departmental cohort of social workers.					
			Level 2: Social Development to provide baseline						
			Level 3a: Social Development to provide baseline						
			Level 3b: Social Development/Health to provide baseline						
			Level 4: Social Development to provide baseline						
			Case management and probation officers						
	Department of the Premier	Appoint Provincial Substance Abuse Co-ordinator in Department of the Premier. Create and manage a single dashboard of all major provincial substance abuse initiatives in provincial departments to ensure alignment with strategy.	No co-ordinator at present	Appoint co-ordinator. Complete transversal programme design, protocols and dashboard	Performance manage co-ordinator	Performance manage co-ordinator	Performance manage co-ordinator	Performance manage co-ordinator	Performance manage co-ordinator
	Department of Social Development	Set up new Western Cape Provincial Substance Abuse Forum (compliant with 2008 Prevention of and Treatment for Substance Abuse Act), used as operational management team	Current Western Cape Substance Abuse Forum needs to be replaced to be brought into line with new laws	Establish new Forum. Hold regular engagements and report to Minister	Hold regular engagements and report to Minister	Hold regular engagements and report to Minister	Hold regular engagements and report to Minister	Hold regular engagements and report to Minister	Hold regular engagements and report to Minister

	Department of Local Government Department of the Premier	Assist municipalities to set up Local Drug Action Committees in compliance with new Act	36 LDACs established by Province, but not tied to municipalities. At present, 1 legally compliant body in Province (run by City of Cape Town)	Identify priority municipalities in collaboration with Department of Local Government, assist via DLG and PCF with establishment of LDACs and formulate Municipal Substance Abuse Plan	50% of priority municipalities with LDACs, holding regular engagements and report backs to Western Cape Substance Abuse forum	100% of priority municipalities with LDACs holding regular engagements and report backs to Western Cape Substance Abuse forum	100% of priority municipalities with LDACs holding regular engagements and report backs to Western Cape Substance Abuse forum	100% of priority municipalities with LDACs holding regular engagements and report backs to Western Cape Substance Abuse forum	100% of priority municipalities with LDACs holding regular engagements and report backs to Western Cape Substance Abuse forum
Improve overall standards of in-house and outsourced services provided by NPO and other procured service providers **Objective:** Supports all 4 objectives of the strategy by improving service standards and outcomes	Department of the Premier Social Development Health	Introduce single integrated IT-based information management system for substance abuse related projects, based on case management information from all Provincial and Province-funded substance abuse treatment, intervention and aftercare programmes and facilities. This will allow monitoring of OUTCOMES in the form of successful treatment cases, by programme, facility and by Province as a whole, and also ensure proper case management approach across the board (i.e. that patients are tracked through the different levels of services and from institution to institution, and so do not 'fall between the cracks' of different services, which increases the risk of relapse). System must also come with improved parameters for Monitoring and Evaluation of services. There is a service quality measures project with MRC and American experts. We could use their outcomes once project is finished. System should also include: • Tracking of bursars, interns and	No single system	Draw up specifications and business plan in consultation with all stakeholders. Initiate design of system.	Implement and apply system for regular performance management	Maintain	Maintain	Maintain	Maintain and upgrade as needed

		learnerships in Province and in Province-funded programmes/facilities • Capacity in provincial run and funded treatment facilities to improve management of case load • Data on substance abuse trends, baselines and other vital research • Minutes of Western Cape Substance Abuse Forum meetings • Other relevant research material							
	All departments	Introduce General Provincial Government of the Western Cape funding policy for substance abuse service providers – based on the national policy implementation guidelines and norms and standards for the new Prevention of and treatment for Substance Abuse Act 2008, which will be formally adopted by 2011, but can be applied as a policy in the interim. The new act sets out clear parameters for service levels 1, 2, 3 and 4. • Introduce standard set of requirements for NPO service providers in each level of service based on the National Policy Implementation Guidelines for substance abuse services. Information on NPO track record and previous M&E reports required to inform decision on funding to be made by independent panel (as per new process introduced by the MEC). • Phase in 'preferential procurement' provisions for provincial government funded services, making accreditation and credentialing a key decider for grant funding and procurement, over and above compliance with norms and standards. Same standards also to be applied to government services. • Include provisions for NPO and other programmes aimed at WCED schools, and introduce departmental policy to prohibit non-conforming service	No policy (new national act, norms and standards, and policy implementation guidelines in pipeline, due to be adopted formally by 2011).	Draw up NPO funding policy based on draft norms and standards 100% Compliance with policy in Department of Social Development Draw up additional preferential procurement provisions in anticipation of accreditation and credentialing systems.	100% compliance with NPO policy by all Departments introduce education and support programme for service providers	100% compliance with NPO policy by all Departments introduce education and support programme for service providers Start phase in of preferential procurement framework - target 25% of all procured service providers conform	100% compliance with NPO policy by all Departments Continue phase in of preferential procurement framework - target 50% of all procured service providers conform	100% compliance with NPO policy by all Departments Continue phase in of preferential procurement framework - target 100% of all procured service providers conform	

		providers from operating in WCED schools. • Include standard requirement in Transfer Payment Agreements (TPAs) with NPOs providing substance abuse related services that require the use of patient surveillance system and capturing of standard case management data for submission into regional case management database • Overhaul Department of Social Development Monitoring and Evaluation system to require performance management of treatment staff employed by NPOs funded by Province.							
improved regulatory framework for substance abuse service providers (measured by successful introduction and implementation of all framework elements –authority, independent accreditation body, set of credentials, set of norms and standards for service providers). **Objectives:** Supports all 4 strategic objectives by: - creating an enabling regulatory framework for service providers so that the Province can use its resources effectively	Social Development Health Department of the Premier	Facilitate establishment of independent accreditation authority linked to international body like the Commission for the Accreditation of Rehabilitation Facilities. Used as government certified mark of service quality for protection of the public.	No accreditation body	Facilitate Establishment of accreditation body	Liaise on an ongoing basis to create and endorse 'quality assurance ' system	Liaise on an ongoing basis to create and endorse 'quality assurance ' system	Liaise on an ongoing basis to create and endorse 'quality assurance ' system	Liaise on an ongoing basis to create and endorse 'quality assurance ' system	Liaise on an ongoing basis to create and endorse 'quality assurance' system
	Social Development Health	Shift 'inspection and licensing' of registered private/NPO and Departmental treatment facilities to Department of Health's Licensing and Inspectorate office.	Registration and compliance monitoring of treatment centres jointly handled by Social Development and Health. Monitoring function is currently being shifted	Shift to Department of Health Licensing and Inspectorate Office completed	Assistance with compliance and ongoing enforcement where necessary	Assistance with compliance and ongoing enforcement where necessary	Assistance with compliance and ongoing enforcement where necessary	Assistance with compliance and ongoing enforcement where necessary	Assistance with compliance and ongoing enforcement where necessary

ILLUSTRATION OF KEY LINKAGES: (This is not an exhaustive set of services and interventions, but illustrates the major linkages. Black boxes represent Drug Demand reduction interventions, grey boxes represent Drug Supply reduction interventions)



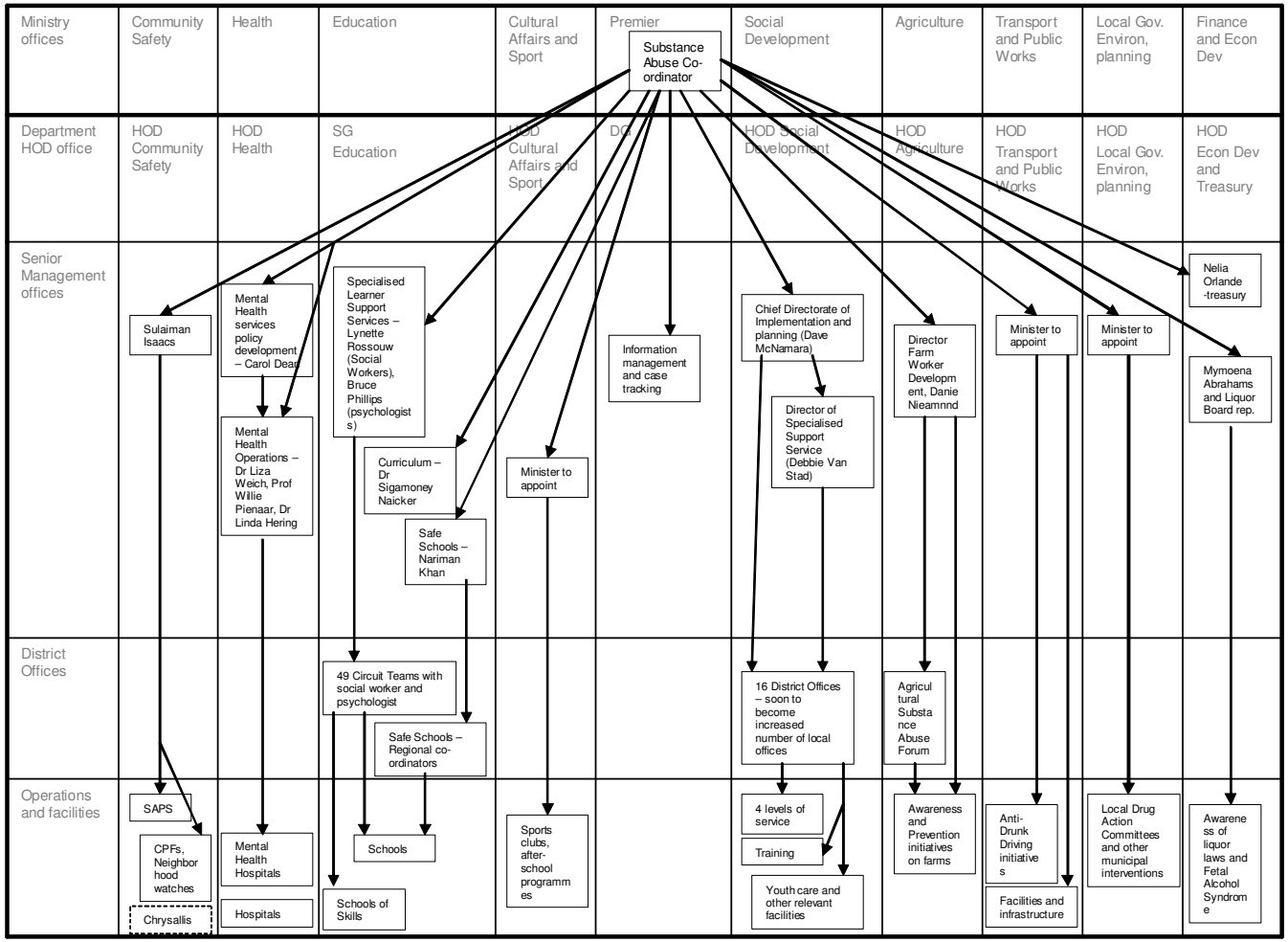
3.3 SHIFTING THE STATUS QUO PART 2 – INSTITUTIONAL FRAMEWORK FOR IMPLEMENTATION OF THE STRATEGY

3.3.1 INTRODUCE TRANSVERSAL ORGANISATIONAL MANAGEMENT STRUCTURE (LED BY CO-ORDINATOR AND TRANSVERSAL SENIOR MANAGEMENT COMMITTEE)

1) Substance Abuse Coordinator in Department of the Premier

2) Department of the Premier Support Personnel for Substance Abuse Coordinator (shared capacity)

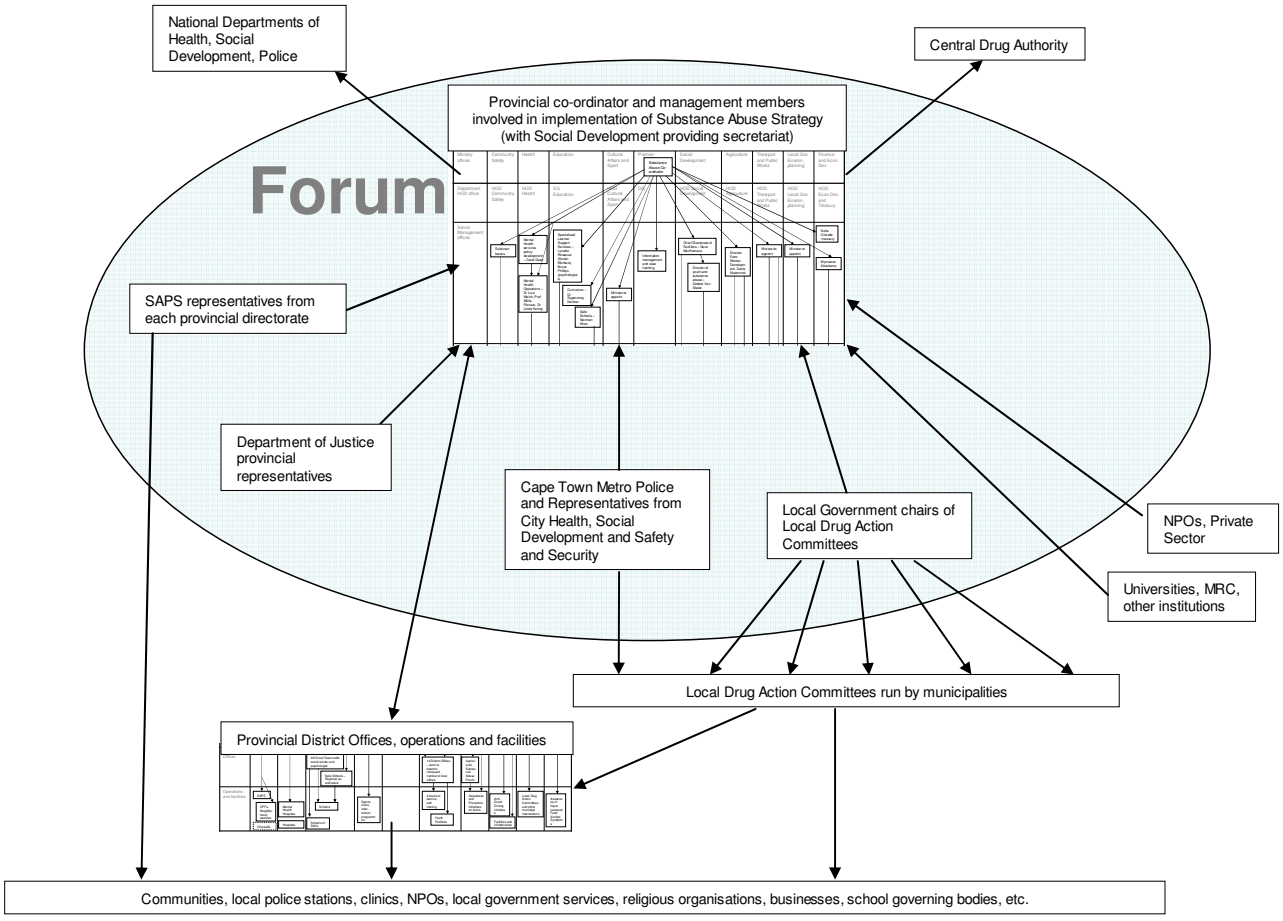
3) One or more 'Key Personnel' in each Provincial Department responsible for Strategy projects in department (in terms of KPAs)



3.3.2 RECONSTITUTE WESTERN CAPE SUBSTANCE ABUSE FORUM AS MANAGEMENT FORUM FOR OPERATIONS AND INTERGOVERNMENTAL/PUBLIC-PRIVATE CO-ORDINATION

Provincial Substance Abuse Forum – Appointed by MEC of Social Development (in terms of Prevention of and Treatment for Substance Abuse Act 2008), Social Development as Secretariat, Chaired by Department of the Premier Coordinator, exco comprising Department Key Personnel. Also on Forum – UNODC representatives, Chairs of Local Drug Action Committees, Heads of SAPS directorates, courts representatives, prosecuting authority representatives (other stakeholders – universities, MRC, etc.)

Diagram: Proposed Structure for the new Western Cape Substance Abuse Forum



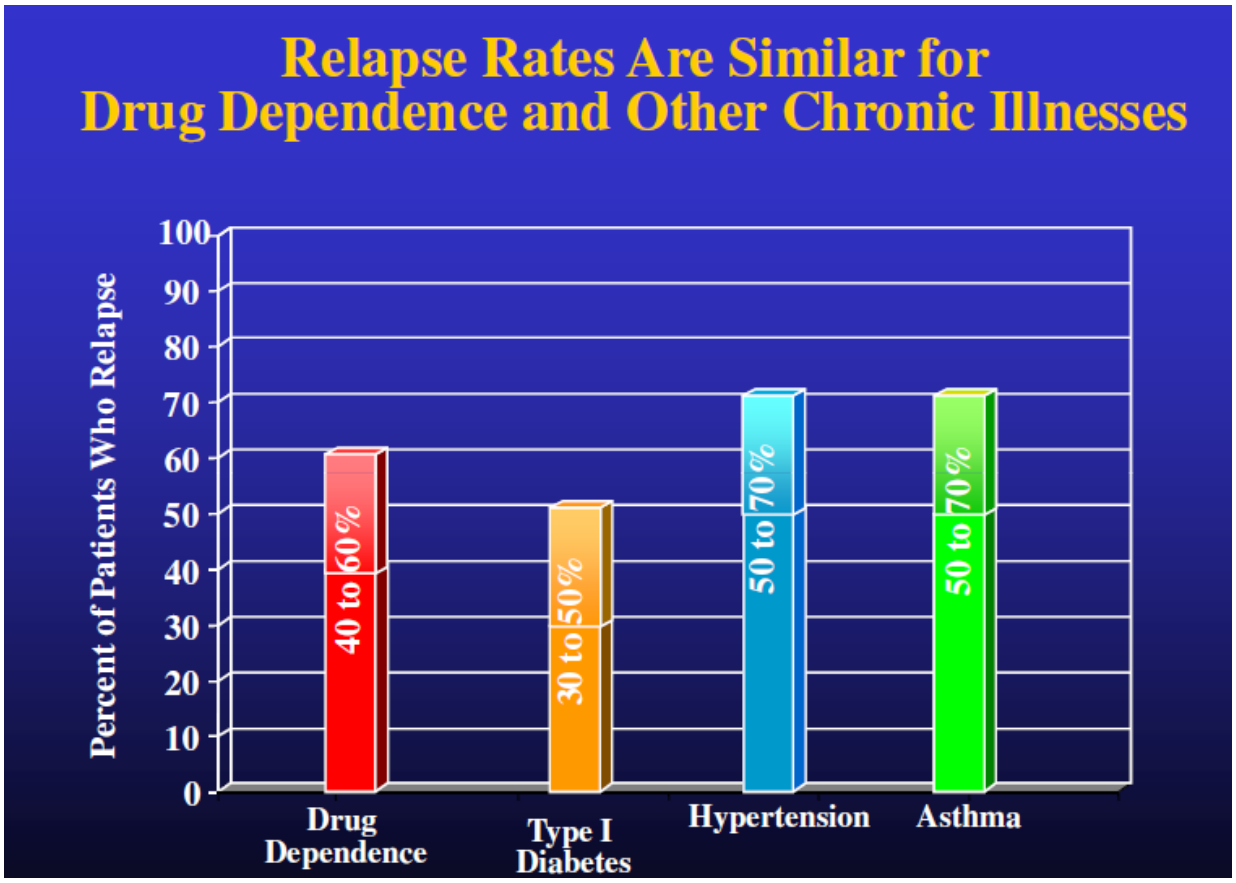
3.3.3 OPERATIONAL MANAGEMENT ON THE GROUND - PHASE IN SEAMLESS SERVICE CENTRE MANAGEMENT MODEL IN AREAS WITH EXISTING TREATMENT SERVICES, WITH STAFF ORGANISED INTO TEAMS THAT DO TREATMENT, ADMINISTRATION LIAISON AND FOLLOW-UP FOR MANAGING PATIENTS THROUGH THE DIFFERENT LEVELS OF SERVICE

3.3.3.1 GENERAL PRINCIPLES

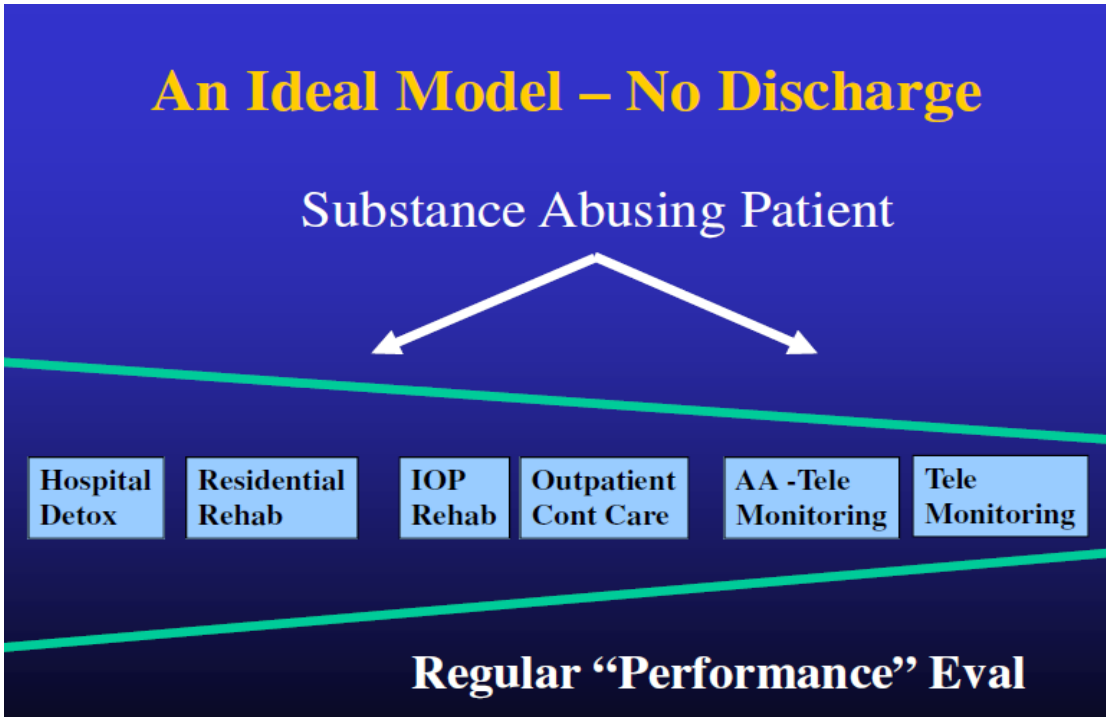
3.3.3.1.1 SEAMLESS SERVICES – THE TREATMENT TRACK

Best practice shows that the success of treatment services hinges on the extent to which various levels of service (levels 1 to 4 in this document) are linked via proper case management. Given the recurring nature of addiction as an illness, it is critical to avoid escalation of substance abuse to the point of acute addiction through **prevention** and early intervention. The principle can be illustrated as follows:

In the case of full-blown addiction, research and international best practice has found that substance abuse programmes are most effective when patients entering the system continue to be monitored and case managed so that they do not simply receive one mode treatment and then get 'dumped' back into their community. Substance abuse has a similar relapse pattern to other chronic illnesses, as the following chart indicates (taken from UCLA research):



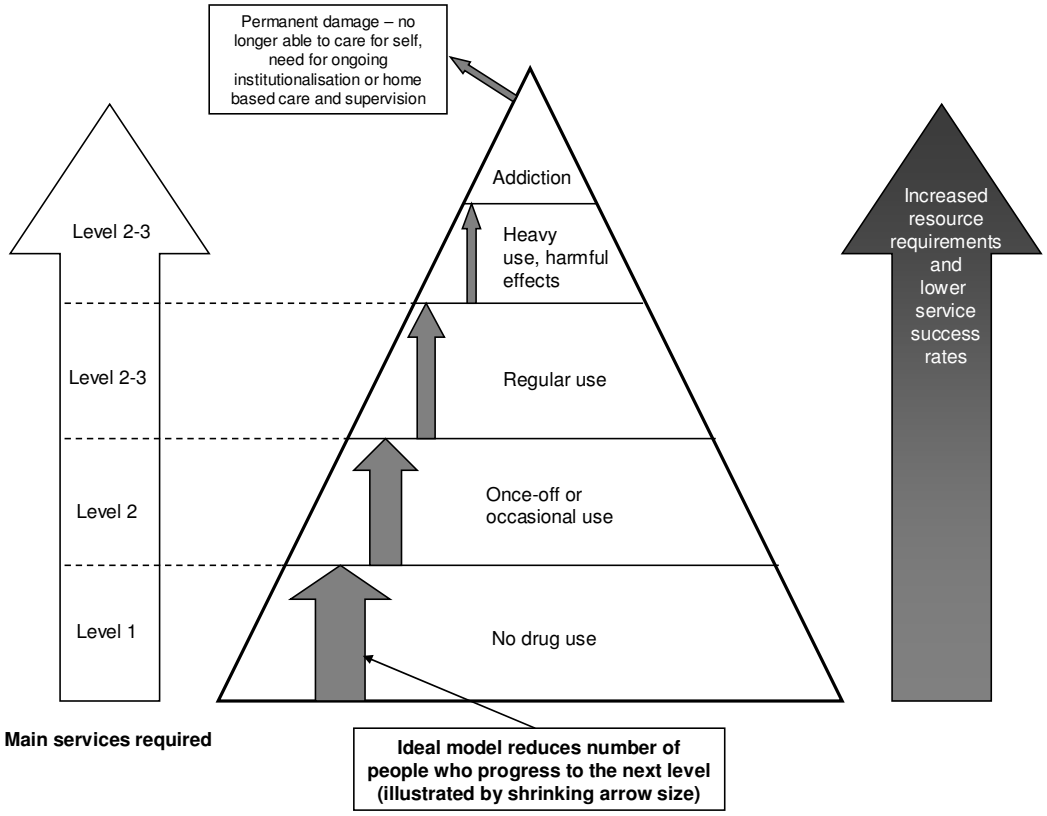
Therefore, simply putting patients into clinics and then expecting them to come out 'clean' is not practical. In around half of the cases (40%-60%), the state will not be getting good return on investment, because the patients risk going back to using. That is why there is a need for a 'treatment track', as per the following diagram, and a range of other non-clinical programmes to put patients into so that they can develop their lives and replace the role that drugs used to play:



3.3.3.1.2 OPERATIONAL POLICY PRIORITIES – 'PREVENTION IS BETTER THAN CURE'

THE IDEAL MODEL FOR RESOURCE ALLOCATION – ARRANGE AND PRIORITISE SERVICES TO MINIMISE PROGRESSION TOWARD HARMFUL DRUG AND ALCOHOL USE ('PREVENTION IS BETTER THAN CURE' – THE KEY ISSUE IS PUTTING ENOUGH EFFECTIVE RESOURCES AND SERVICES INTO PREVENTION. TO MAKE THE OTHER LEVELS OF SERVICE MORE EFFECTIVE, LIAISON, AFTERCARE AND FURTHER SKILLS AND OTHER DEVELOPMENT PROGRAMMES ARE CRUCIAL).

It should also be emphasised that with some patients the chances of full and permanent recovery are very low. In such cases, provisions and policies need to be considered and costed for ongoing mechanisms/institutions for minimising the harm that these individuals can do to themselves and to others):



3.3.3.2 AREAS OF SERVICE AT OPERATIONAL LEVEL

3.3.3.2.1 AWARENESS AND PREVENTION – LEVEL 1

Awareness and prevention services need to be evidence-based – i.e. based on tried and tested practices that are tailored to the local context, monitored, and adjusted as needed. They should also be linked to other programmes (for example, one of the most effective ways to secure school learners against starting to use drugs is to engage them in after-school activities – during the time that they are most at risk due to the lack of supervision. This is particularly important for learners whose parents are absent from the home due to work or other reasons). Information and education material should be credible (especially to the target audience) and mainstreamed into school curricula in order to maximise cost efficiency and sustainability. Separate information must also be made available to adults, parents and relevant professionals. Other forms of prevention include early identification of high risk children, and, where indicated, sustained support services for these individuals (Level 2) in their existing environment (or, where absolutely necessary, in a separate residential programme).

Cognisance must be taken of international research findings on what kind of prevention initiatives work and don't work.

For example, the International Drug Policy Consortium makes the following recommendations for prevention programmes:

- Before starting to design a prevention strategy, clear objectives must be set
- Prevention strategies that may have unintended negative consequences on the target population should be avoided (eg. risks of inappropriately managed school testing and search operations)
- Traditional drug prevention policies need to be included into a broader strategy based on the socio-economic and health development of citizens, with a particular focus on the communities at higher risk. To that aim, governments should identify the needs of the most vulnerable communities before designing appropriate drug prevention strategies.
- It is necessary to involve key players, including dependent drug users and their families, in the effective design and implementation of prevention strategies. Affected communities should continually participate in the process to make sure that the measures undertaken are properly targeted and will not have unintended negative consequences.
- Data needs to be gathered to regularly assess the impacts of national socio-economic development programmes on the prevalence of drug use in communities. This will make sure that best practice is clearly evaluated and evidenced for future interventions.

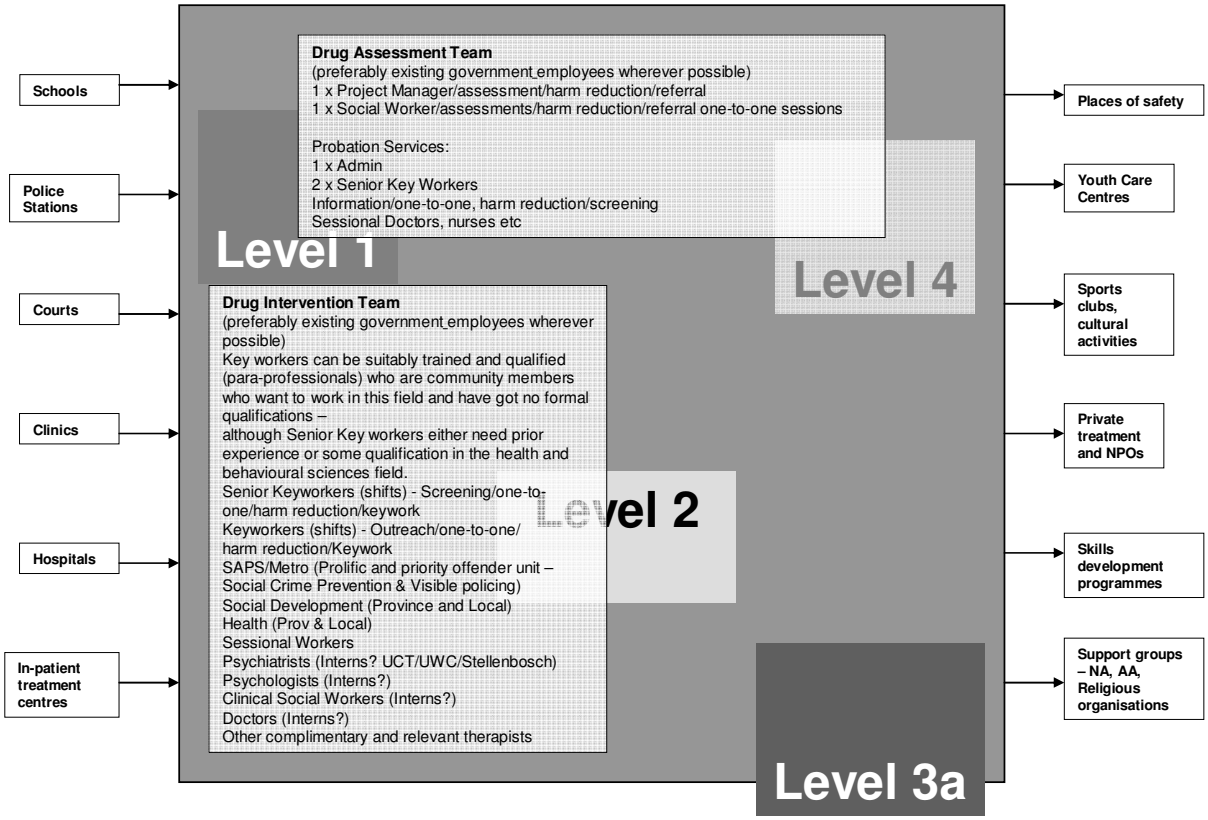
3.3.3.2.2 CLUSTERING INTERVENTION SERVICES - SCREENING, ASSESSMENT, BRIEF INTERVENTION (LEVEL 2), AND AFTERCARE (LEVEL 4)

In order to match services with need, people coming into the system (in the case of young people, via referral from principal, school social worker, or other social worker, in the case of young people and adults, via the courts, referral by a medical professional or hospital, or by self admission) need to be correctly screened, assessed, logged onto an IT system and referred to appropriate treatment services. The treatment needs to be reviewed regularly, and the patient should be referred to less intensive treatment and/or aftercare and recovery services as soon as is appropriate.

Patients also need to be linked to support programmes (like Narcotics Anonymous) and other activities (for example, recreation under Cultural Affairs and Sport, skills development under EPWP or Economic Development programmes etc) once they have recovered in order to minimize risk of relapse (and the higher costs to the state that this incurs). This also requires follow-up and monitoring of the patient, hence the need for further case management even into the aftercare phase.

It is therefore critical that case management systems and case managers are in place (Case managers should not only screen and refer, but should motivate and prepare patients for treatment and time interventions well, and thus requires appropriate training and skill levels). The clustering of treatment centres, with case managers, treatment specialists or auxiliary staff doing active liaison work is therefore the most efficient way of integrating and generating maximum benefit from the set of services (and skills) that fall under levels 1-4, and also helps to ensure that patients do not drop out of the programme due to travelling constraints or lack of direct follow up. In some areas it may be possible to offer the full range of services in levels 1-4 (excluding 3b or in-patient treatment if necessary) in one 'Drop-in' Centre. However, even if facilities are clustered in reasonably close proximity, the basic management principle of seamless services (or a continuous 'treatment track') can still be effective. Below is a rough diagram of the concept.

Treatment Track Centre or Cluster Should group DOSD Service levels 1, 2, 3a and 4 in close geographic proximity, with relevant professionals working in teams, and liaising closely with local facilities where referrals come into the Cluster and out of the cluster to support systems



Staff in these centres/clustered facilities can be arranged into teams in order to maximize the efficiency of substance abuse services and operations directly included within the centre/cluster, and also services linked to it externally (for example, social workers and counsellors in nearby schools, in-patient treatment facilities and so forth). The management model of Drug Intervention and Drug Assessment Teams is used as an example in this case. A Drug Intervention Team (DIT) can be set up with outreach- (i.e. can be deployed to police stations, schools and courts, for example) and office-based workers who engage with drug users and their families. They need skills in motivational interviewing and liaison and other key work will be an integral part of their job. They will engage with clients and their families and motivate them to go to the next level of care; as well as giving advice on how to reduce the harms caused by drugs. Drug

intervention teams could include police or law enforcement staff, social workers and social auxiliary workers, probation officers as well as other service providers. The Drug Assessment Team (DAT) comprises some outreach and office based workers in partnerships with the relevant agencies such as Correctional Services, Probation, SAPS as well as government and local private mental and physical healthcare professionals and service providers. The Drug Assessment Team would work with all clients, even those who are not yet ready to stop using drugs, and if necessary develop a care plan for them and their families. There can be structured daily brief intervention programmes; although not at the level of formal rehabilitation. Instead these programmes will prepare the patient to enter the next tier of treatment and reduce the damage to the family by providing low level day programmes and appropriate activities (these support services should also make provision for child care for mothers attending). The Drug Assessment Team can also deal with people who have special needs e.g. women, people in conflict with the law, people who are homeless, people with mental and physical health problems, people with HIV/AIDS and other communicable diseases such as TB. The core functions of the Drug Assessment Team, in partnership with the relevant state and private service providers, would be:

- One-to-one assessments and appointments
- Care management and care planning
- Arrange appointments with relevant healthcare services
- Prepare client to go on to an abstinence based rehabilitation service
- Provide a safe space in which clients can explore their motivation around stopping/reducing their alcohol/drug use.
- Advice and Information
- Women specific interventions, particularly advice for drug using pregnant women or women with children
- Domestic Violence and Sexual Health advice
- Help clients to get some structure and stability into their lives
- Provide clients with some basic living skills through workshops
- Provide practical assistance with education, training and employment issues
- Referral to other agencies

3.3.3.2.3 CLUSTERING INTERVENTION SERVICES – LEVEL 3a

The centre/cluster can also incorporate level 3a services (outpatient treatment), and where necessary existing social workers and clinicians can divide their time between counselling services and time dedicated to triage assessments and brief interventions. This is useful in contexts where skills are in short supply. The Provincial Government sponsored (and SANCA run) Sinethemba project works roughly on this principle, and is producing promising results according to the monitoring and evaluation report on the site. Moves are currently underway to link it with the GF Jooste Hospital, which is experiencing high intake of patients with acute substance abuse related trauma. The Province and City of Cape Town are also currently forging a partnership for similar integrated services in two other sites as further pilot projects. It is important that Key workers from the Drug Assessment Teams **liaise** closely with courts (and probation officers), as well as schools (via social workers), police stations and hospitals in order to maximize intake of patients for treatment, and also **follow up** on clients that have been referred to other levels of service within the treatment track (in order to ensure that they actually enter the stepped down programme). Even in level 4, regular urine testing, weekly counselling and/or telephonic follow-up are often indicated.

The proposed project requires co-operation between government departments (such as SAPS, Social Development & Health (City & Province), Justice, DCS, NPA and the relevant private for profit and not for profit organisations; as well as local business and community structures and groups.

3.3.3.3 SKILLS DEVELOPMENT

All skills development should be accredited and workers on this project should be able to acquire further qualifications, or specialist qualifications, in line with the IC & RC (International Credentialing and

Reciprocity Consortium). This will also create 'career-pathing' options for Social Development, which will in turn encourage more professionals to enter the field, since Social Work is sometimes perceived to be a 'dead-end' career (although this needs to start off in a relatively simple form).

Province could set its own standards based on these – much like other states/provinces/counties around the world. E.g. There are moves underway to enable Doctors and Psychiatrists to qualify with SASAM (South African Society of Addiction Medicine – driven by Prof Rataemane from Pretoria University) which is part of ISAM (International Society of Addiction Medicine). The Western Cape Provincial Government is also working toward an addictions psychiatry sub-specialty under the Health Professions Counsel (as mentioned above). A points system could also be introduced for social workers to build into a specialist credential as an Alcohol and Drug Counsellor, and then add-ons like drug court professional; Psychiatrists/Psychologists/Level II counsellors can get a specialist qualification to deal with Dual-Diagnosis.

The non-specialists/para-professionals can work towards qualifications such as 'Drug Prevention Specialist', this will give them CPD points towards a higher level of qualification – such as the first level of registered substance abuse counsellor (a recognised professional qualification). However, the NQF and SAQA need to be involved in this as the current standards lie within the Services SETA. Health & Welfare SETAs standards are inadequate and outdated. For those para-professionals who have been counselling for years, their prior learning and experience is taken into account for credentialing as either Level I or Level II Alcohol and Drug Counsellor.

Criteria need to be developed for non-specialist outreach and other key workers which are currently working with drug treatment programmes, as well as for new recruits. (Alcoholics Anonymous recommends that recovered chronic drug users only begin to work as counsellors after 3-5 years of non-use. For people who have previously used drugs or come from an alcohol/drug affected family, their wellbeing and safety needs to be the primary concern, and there needs to be excellent support and management structures in place.) The relevant requisite basic skills for non-specialists are listed below:

- Basic Drug & Alcohol Information
- Motivational Interviewing
- Screening and Brief Interventions
- Assessment

4. CONCLUSION

This Blueprint sets out a detailed proposed provincial strategy for shifting the Provincial Government's current operations to address substance abuse (the Status Quo) to a more intensive and integrated approach, designed to produce improved outcomes in terms of 4 strategic objectives of the project, which in turn support the overall 10 strategic objectives for the Province. The Blueprint also contains an interdepartmental, intergovernmental and inter-agency framework for implementation of the strategy.

Given the limited time available, and given the general shortage of research and data in this field, there are still some information gaps, and several important steps still need to be taken:

1) MTEF budgeting at department level for the implementation of the project, and adjustment/alignment of Departmental APPs where necessary
2) Baseline research in a number of areas (school drug use rates, total burden of disease studies, evidence-based learning and teaching support material for Life Orientation, identification of foetal alcohol and violence hotspots)
3) Establishment of a functional monitoring system to measure outcomes, i.e. number of persons that are *successfully* treated, not simply number of persons treated, without any differentiation between those who repeatedly return. The longer term outcome that must be measured is the overall reduction in prevalence, which can be measured District by District, starting with schools, and also using other indicators such as SAPS crime statistics.
4) Establishment of a dashboard to measure progress toward outcomes

5) Development of protocols to manage the transversal project vis-à-vis the Provincial Department lines of authority
6) Clarifying linkage points between other transversal projects – particularly after-school programmes run between the Department of Cultural Affairs and Sport and the Department of Education, as well as the provincial community support structures workstream and transversal youth programmes – including the rationalisation of youth centres and the shift of certain youth centres to the Department of Social Development
7) Clarifying the role that the Provincial Government can play in supporting police forensics and the expansion of diversion services from courts
8) Exploring alternative training options for existing provincial staff
9) The UNODC's potential role in assisting with this Strategy and Framework is still being finalised
10) Finalising and implementing interventions to give teeth to the new Western Cape Provincial Liquor Act

Several department by department recommendations to cabinet follow in the next section.

RISK MANAGEMENT

All projects that arise out of this Modernisation Process will be supported by a Risk Mitigation Plan. The risks associated with the project must be identified, together with the plan to manage those risks and a person assigned to manage each risk.

Risk	Risk Reduction Plan
1. Reliance on agencies which are national or local government competences	High level intervention by premier or designated nominee to secure commitment and sustained co operation
2. Changing community dynamics and a reliance on voluntary effort	Regular communication with and feedback to targeted communities and stakeholders Incentives for the voluntary effort e.g. training, vouchers Publishing/popularizing success stories. Local Drug Action Committees should be led and convened by local government. Provincial Department of Local Government must support this.
3. Weak legislative framework for substance abuse services, particularly around outpatient treatment, aftercare, early and brief interventions.	New legislation, regulations, policy implementation guidelines, and norms and standards at national level are being finalised to improve some of these areas, and the Provincial Government of the Western Cape is directly involved in these processes. Province is also free to draft Provincial Legislation and preferential procurement policies to improve quality of services it procures

4. Sustained commitment from all parties for the duration of the project	The deliverables of this strategy to be incorporated appropriately into the relevant APPs of line departments, and in the performance agreement of responsible department officials. Effective monitoring mechanisms and early warning signals to be put in place and centrally monitored via a dashboard located in the Premier's Office. Each major operational element of the project must be built into line functions of departments in order to remain a sustained part of standard provincial budgeting cycles and service provision.
5. Inability to calculate the exact resource costs required for this project due to time constraints and the many variables that impact on the scope of the work	A more detailed costing will develop over time as financial modelling for new projects is completed.
6. Poor data management and lack of adequate information on outcomes of services provided (lack of performance management system).	Develop comprehensive, centralised database for tracking of patient trends and case management of each patient to detect relapse rates and overall success rates. Baseline studies needed in key areas to track success rates and failures of interventions (for example, substance abuse trends in schools)
7. Lack of basic skills in the field (i.e. qualified social workers/psychologists/psychiatrists), lack of specialised skills in the field (i.e. prevention and treatment of harmful drug and alcohol use is a specialisation within these general disciplines, but is a very new field for SA. There are therefore almost no specialists available).	Develop and fund training programmes in partnership with the major universities (bursaries and funded academic posts), recruit graduates.
8. Scale of challenge around illegal shebeens, possibility of violent response to enforcement and limited police capacity	Ensure strong communication and co-ordination between police, liquor board, shebeen associations, and local government
9. Transversal nature of project creates conflict with existing departmental reporting lines, budget processes and protocols	Develop set of protocols for management of the project that harmonises transversal project with departmental reporting lines. The performance management system on the transversal project monitoring and evaluation processes as well as budget planning and APP processes need to be reconciled with departmental M&E, APP and budget processes. More detailed proposals for this follow below.

5. SUMMARY

The strategy and its supporting framework do not seek to reinvent the wheel. They draw on and build upon existing services, laws and management frameworks (for example, the supply and demand side distinction, and the DOSD's 4 levels of service), existing national laws (and pending laws, norms & standards, and policy implementation guidelines), and on systems and practices applied successfully in

other parts of the world. They also do not have major budgetary implications over and above what is already spent, will ensure greater value from what is spent, will extend the benefits of the spending to more citizens, shift toward an effective and sustainable prevention approach, and in the long term will help save the Provincial Government considerable amounts associated with the burden of disease. The main shifts are:

- the centralisation of all interventions under a single co-ordinator – increasing transversal linkages across departments, and stronger inter-governmental co-operation (including the reconstitution of the Western Cape Substance Abuse Forum as a legally compliant transversal and intergovernmental co-ordinating and operational oversight body)
- introduction of a centralised IT based information management system to allow for monitoring of outcomes, not just outputs, to match services provided more closely with need, and to facilitate better case management between levels of service. The system will be linked to decentralised IT based case management systems for all provincial facilities and treatment programmes.
- Introduction of tighter quality control over PGWC funded services and service providers
- A major drive to build specialised and semi-specialised skills in the field in partnership with the major universities
- adjustments to certain departmental reporting lines in order to improve efficiency, as part of the overall Modernisation Process.
- elimination of duplication and/or non-performing projects and processes
- elimination of ineffective and/or outdated communication and treatment practices
- greater emphasis on early prevention via increased social worker and psychological counselling services in schools
- Increased brief intervention services
- Building capacity of aftercare and recovery services, which are currently almost non-existent in the province, and are mostly semi-formal where available. This is critical to save funds on repeated intensive treatment for relapsed cases.
- Increased focus on substance abuse in rural areas (including the Department of Agriculture, particularly to address Fatal Alcohol Syndrome and FAS spectrum disorders)
- Shift toward building in-house capacity within the Provincial Government, while also concentrating more funds on fewer, well performing NPO partners
- Greater involvement of Universities, local and international research organisations to ensure that we are applying practices that are proven (through sound methodologies) to deliver successful outcomes
- Leverage maximum benefit from new provincial legislation on Community Safety Police oversight role, and Provincial Liquor Act
- Increased co-ordination with, and involvement of, municipalities, in terms of the National Drug Master Plan (2006-2011), with an emphasis on encouraging and helping key municipalities set up Local Drug Action Committees, whose chairpersons will then be included on the newly formed Western Cape Substance Abuse Forum to improve co-ordination and implementation of projects.

The strategy will rely for its success on the extent to which its projects are mainstreamed into the Western Cape Provincial Government's departmental line functions and operations, the level of skill and motivation of key personnel within the organisational structure, together with good information systems and rigorous performance management.

6. RECOMMENDATIONS

It is recommended:

1) that Cabinet adopt in principle the Provincial **Framework** and **Strategy** for the Prevention of and Treatment for Substance Abuse, as contained within this Blue Print, with the proviso that the specific items in Section 3.2 and Section 7 are finalised and agreed upon between the co-ordinator and the department concerned.

2) that Cabinet mandate the Provincial Substance Abuse Co-ordinator in the Premier's Office to co-ordinate substance abuse related projects across departments by:

a) ensuring the alignment of departmental budgets with the objectives of the framework and strategy contained within the Blue Print
b) ensuring a uniform approach, as defined in the Blue Print, for the Prevention of and Treatment for Substance Abuse
c) directly reporting to Cabinet through the Premier
d) establishing and chairing an interdepartmental senior management co-ordinating committee to assist with driving the implementation of the strategy

7. DEPARTMENT SPECIFIC IMPLICATIONS OF THE STRATEGY AND FRAMEWORK

Department of the Premier

1) The appointment of a Substance Abuse Co-ordinator in the Premier's Office, with delegated authority to co-ordinate all departmental projects that fall within the Western Cape Prevention of and Treatment for Substance Abuse Strategy, and to lead co-ordination with other state and non-state bodies outside of the Provincial Government.

2) The development of a central information management system for the Substance Abuse Strategy, under the direction of the Substance Abuse Co-Ordinator, with the support of the Department of the Premier's IS&T Chief Directorate and the Department of the Premier's Information Management Unit, to monitor:

a) The movement of patients through the Western Cape Provincial Government or Western Cape Provincial Government-funded treatment centres in order to track success rates and relapses and actual outcomes of the Strategy's implementation. This should be linked to Departmental regional case-load management systems to be developed and implemented in each district (see recommendations for the Department of Health).
b) To monitor available and used capacity with all Provincial Government and Provincial Government-funded substance abuse programmes (to determine need and capacity to meet need)
c) Availability of staff members serving all 4 levels of services to address substance abuse (within Provincial Administration and outsourced)
d) Available bed space and available spaces in programmes funded/run by Provincial Departments to manage and co-ordinate caseload
e) Overall indicators of the strategy's impact, including school drug use trends, drug supply patterns etc.

Said system will be crucial for measuring outcomes of treatment services, and will be accessible to all relevant PGWC officials in the Departments of Health, Social Development and Education. It would draw data from Department of Health and Department of Social Development district case management monitoring systems, treatment and intervention facilities, and, once set up, the DOSD local service delivery teams.

3) The creation of a transversal dashboard for monitoring the implementation of the substance abuse strategy for the Provincial Government of the Western Cape. Implementing a DOTP communication; research; information management and monitoring strategy & Dashboard is in the process of development as part of the overarching modernisation strategy with the development of monitoring & evaluation frameworks through the provincial dashboard *(See- DOTP – Dashboard Process Document)*.

4) Drafting and implementing a single funding policy for all NPO substance abuse service providers seeking funding from Western Cape Provincial Government Departments, applicable to service levels 1-4 (as defined in this document) as well as to training and research services (based on the norms and standards

that are currently being drawn up for national government by the Western Cape Provincial Government, as well as national policy implementation guidelines). The policy must focus on using M&E information (or other verifiable track record information where NPO has not previously served Province) to decide on eligibility for funding, and to determine continued, increased or decrease funding (linked to performance). M&E information must also require performance management of key treatment staff in NPOs. Capacity to utilise the Department of Social Development's patient Surveillance System in all relevant facilities and capture case management data in line with new National Norms and Standards to feed into the regional case management database is also necessary (in order to create the information basis for proper overall monitoring of strategic outcomes, and proper seamless case management at operations level). Basic principles of the new National Policy Implementation Guidelines must also be applied to the various funded treatment levels. These requirements must also be included as a condition for payment in terms of the Transfer Payment Agreements (TPA).

5) Provincial Government Substance Abuse Co-Ordinator to enter into a partnership with the Cape Higher Education Consortium to develop a research, curricula development and implementation, qualification development, bursary and fellowship agreement between the Provincial Government and the individual CHEC Universities, subject to final approval of the agreement by Cabinet.

6) Department to investigate constitutionally compliant special legislation for courts to declare properties where known drug dealing suspects reside and/or multiple drug related arrests have been carried out as 'suspected drug trafficking points', in terms of which certain types of surveillance and other equipment on the property can be restricted. Community Safety will begin this process by obtaining provisional legal opinion on constitutionality of such legislation from provincial government internal legal offices, which will then be used as a basis for proceeding.

7) Department to facilitate the establishment of an independent, industry controlled, credentialing body for substance abuse professionals.

Department of Health

1) Increased level 1 and 2 services in high-risk populations in health facilities

2) Full investigation into needs for increased community-based mental health services (for adults, children and adolescents).

3) Roll out of new awareness programme around alcohol related harms 'Booza TV' in communities with high alcohol-related harms and other important stakeholders

4) Consolidation of registration and regulation function for treatment facilities in Department of Health (currently the function is split across DOSD and Health)

Department of Social Development

1) Development of a full treatment track of complementary services at levels 1-4, as per the model set out in this Blueprint. The aim should be to achieve a better balance of services to strengthen prevention, minimise relapses and lost resources expended on unsuccessful treatment, to expand the reach and accessibility of services, to improve liaison and linkages between different levels of service, as well as between related services and facilities and other relevant nodes where citizens present with drug related disorders (i.e. hospitals, clinics, social work offices, police stations, community and magistrates courts etc). This is to be done within the context of the Department's overall restructuring of its service delivery structures into District Offices and subsidiary 'service delivery teams', which are to be aligned with the Department of Education's Districts and Circuits.

2) A geographic and sectoral needs analysis for substance abuse intervention and treatment services in the Western Cape must be carried out to determine the optimal type and level of services to be offered in each District. The core policy principles that must be applied are:

- reaching as many citizens as possible while still providing effective interventions
- targeting citizens who are engaging in alcohol and drug use as early as possible in their development so that progression to more harmful use or full-blown addiction can be prevented wherever possible
- determining where limited departmental resources can be utilised to create the most possible benefit in terms of reducing drug and alcohol related harms
- determining which interventions are currently working well, so that best practices can be duplicated and expanded

Given the focus on prevention, the first phase of the analysis is to be done by the Department of Social Development, in partnership with the Department of the Premier and Department of Education, into substance abuse trends in schools, and will result in a full report with recommendations that can guide resource allocation by district, as well as provide baselines for monitoring and evaluation purposes.

3) The development, in partnership with the Department of the Premier, of a dedicated, IT-based, web-accessed, case-tracking system for all individuals who enter the Provincial Government's substance abuse related services, so that they can be case managed and tracked through a full treatment track. The system must have access points for all relevant service providers (including service delivery teams) and programme management, be compatible with other databases (Clinicom in the Department of Health, SDIMS in Social Development, and Home Affairs for cross-verification of Identity). It must capture patient data as collected during Triage assessment, must track patient movement through service levels and different institutions, and must record treatment incidents, including successful recovery). It will be used for monitoring and evaluation of all Provincial Government run or funded programmes. The personal data must remain confidential and secure.

4) A major shift in focus to increased prevention services, particularly for young people abusing drugs or alcohol. This will also include aiming treatment services for younger citizens (starting with the establishment of an inpatient treatment programme for exceptional youth cases, as well as a pilot project in high risk schools where a specialist counsellor is deployed to conduct a Matrix or similar outpatient treatment programme for learners with serious drug problems). It will also include strengthened brief intervention and referral support structures for schools and after-school services (via the DOSD's new service delivery teams, in liaison with school circuit teams).

5) An additional shift in focus to providing services in rural areas, in partnership with the Departments of Agriculture, Health, and Cultural Affairs and Sport.

6) An additional shift in focus to providing aftercare services (level 4). The National Department of Social Development also supports this, and has requested that the Western Cape Provincial Government pilot 2 Aftercare programmes.

7) A medium term strategy to increase the number of substance abuse professionals employed by the Department of Social Development upon the completion of a needs analysis by the Chief Directorate Implementation and Planning, as part of the overall departmental Human Resource Plan (which envisages the recruiting of approximately 800 social workers and/or social auxiliary workers over the MTEF), and subject to a cost-benefit analysis on in-sourced vs outsourced services, and subject to a needs analysis of priority treatment areas (both geographic and in terms of the balance of services between levels 1, 2, 3a, 3b and 4, as well as probation officers).

8) Linked to 7, funding the development and implementation of a module-based post-graduate diploma in the prevention of and treatment for harmful alcohol and drug use, for implementation in Western Cape Universities, together with annual funding for bursaries, learnerships and placement of graduates. Diploma

course convenor and teaching capacity to be appointed with financial support from Province, and modules and teaching time to be made available for certain related degrees (such as BA (Hons) Psychology and BA (Hons)/MA Clinical Social Work).

9) A short-term plan must be drafted and implemented to separate non-offender patients in provincial in-patient (level 3b) facilities from offender patients. Currently the Department-run De Novo Treatment centre combines these two categories of patient in one facility, which runs counter to best practice.

10) Linking of youth care facilities to substance abuse programmes – so that residents can access these programmes, and also so that youth discharged from in-patient treatment can access places of safety where this is indicated (see also point 3 under the Department of Community Safety section below).

11) A review of the Ke Moja, Peer Support, and FASFacts drug and alcohol awareness programmes that are currently run in WCED schools to determine their effectiveness, and adapt or replace the programmes where the Provincial Government's objectives are not being met.

12) The drafting and implementation of a funding policy for NPO substance abuse intervention service providers to ensure that grant recipients which are performing well are given additional support to expand their services.

13) Facilitating the establishment of a credentialing authority for AOD service professionals in order to improve quality control, career-pathing and the efficiency of state funding allocations in the AOD sector.

14) Expanding the capacity of the Department's probation services in order to carry out diversion of first time/ minor cases of drug users from the courts into treatment programmes and community service. This will begin with prioritising the permanent assignment of probation officers to Community Courts, (permanent deployment of at least one probation officer to each of the three Community Courts in the Western Cape). Thereafter, the department will redeploy its probation officers within the context of its 3 year plan to introduce 49 local Service Delivery Teams (in terms of the Departmental modernisation program). It is recommended that the overall staff capacity of probation services be increased to at least 100 probation officers and 100 assistant probation officers as part of Department's recruitment drive. This should be reviewed and adjusted as and when additional capacity is required.

15) Strategy to rationalise and strengthen the services offered at places of safety and Special Youth Care Centres to ensure that these centres operate on best practice principles and are linked to substance abuse programmes where needed.

Department of Education

1) Ensuring evidence-based teaching material is incorporated into future textbooks for Life Orientation.

2) Working in partnership with DOSD to increase the availability of suitably trained social workers to provide psycho-social support services, counselling and referral of learners with serious behavioural and substance abuse disorders to suitable service providers (with the aim of freeing up teachers and principals to focus on task, to reduce classroom disruptions, and to prevent the progression of alcohol and drug problems among young learners). This will also include a review of the current institutional arrangement of social workers serving schools under the Education Department's Directorate of Specialised Education Support Services. Either way, it will require improved liaison and co-ordination between school social workers and the new service delivery teams to be established by Social Development. A policy must therefore be drafted to set out the procedures and institutional arrangements in terms of which DOSD social workers will work with schools and school circuit teams.

3) Drafting of a formal policy to regulate all substance abuse related programmes proposed for WCED schools by NPOs, private individuals or other government departments. The policy will prohibit programmes from being run in WCED schools unless certain key criteria are met.

Department of Agriculture

1) Continued support by the Department of Agriculture for the Western Cape Agricultural Sector Forum on Substance Abuse, provided that this Forum is linked into the newly-formed Western Cape Substance Abuse Forum to ensure optimal co-ordination.

2) Needs analysis and feasibility study to be conducted into substance abuse and Fatal Alcohol Syndrome and FAS Spectrum Disorder prevention interventions and treatment services in rural areas, and a management model thereof which takes into account the unique geographic and logistical challenges of rural areas. This must be done in collaboration with the Substance Abuse Co-Ordinator and the relevant officials in the Departments of Social Development and Health.

3) Pilot project on providing primary health care, brief interventions and alternative recreational activities on farms, in partnership with Cultural Affairs and Sport, and the Department of Health.

Department of Local Government

1) A liaison and support initiative to be undertaken by the Department of Local Government targeting priority municipalities for the roll-out of Local Drug Action Committees (which will either absorb existing informal LDACs or incorporate representatives from these informal community organisations) and Municipal Prevention and Treatment for Substance Abuse plans in line with national legislation and the National Drug Master Plan 2006-2011 (which will also take into account the role of infrastructure in crime reduction). The Minister is asked to nominate a lead individual in his department to liaise with the Provincial Substance Abuse Co-Ordinator for this purpose. The project will be raised with municipalities in the Premier's Co-ordinating Forum.

Department of Economic Development and Tourism

1) Inclusion of Chief Executive Officer of the Liquor Board on Substance Abuse Forum, to help co-ordinate use of funds that he or she is required to allocate for:

- combating the negative social consequences of the abuse of liquor
- educating persons engaged in the sale and supply of liquor; and
- educating the general public in the responsible sale, supply and consumption of liquor.

2) Finalisation and execution of a comprehensive strategy for the implementation of the new Western Cape Liquor Act.

3) Setting up a monitoring mechanism to compare liquor licenses granted with SAPS and municipal statistics on liquor outlets in order to detect and monitor margin of illegal outlets, and monitor the effectiveness of enforcement efforts.

Department of Cultural Affairs and Sport

1) Incorporation of evidence-based prevention programmes with new Mass Opportunity Development (MOD) Centres for after-school sports.

2) Linkage of MOD centres with aftercare programmes for young people

3) Gaining additional for extended MOD centre programmes in high-risk areas, and developing partnerships with Safe Schools, DOSD and others to ensure maximum effectiveness of these programmes.

Department of Transport and Public Works

1) An MTEF strategy to extend the use of Drager alcohol analysis machines in partnership with Community Safety to at least four additional locations or mobile units in the Cape Metro region, as well as a mobile unit to serve other Provincial regions as the priority arises (subject to the success of the Drager analyses in court).

Department of Community Safety

1) A mechanism for co-ordination between this Workstream, Framework and Strategy and the Community Support Structures workstream in order to maximise outcomes of interventions to reduce drug supply.

2) The prioritisation of closing down major drug trafficking organisations, drug retail points and drug production sites in the Western Cape Provincial Government's Provincial Priorities for SAPS in terms of the Provincial Government's Constitutional Monitoring and Oversight role, and any legislation connected thereto.

8. HUMAN RESOURCES IMPLICATIONS

The management level staff required for the implementation of this Framework and Strategy are already in place in the various government departments, as indicated in the transversal organisational structure proposed in Section 3.3.2. In addition to this, the programme may require the following:

1) The formal appointment of 1 project co-ordinator in the Office of the Premier at Level 13, as indicated within the proposed organisational structure in Section 3.3.2. A proposed job description has already been drawn up and submitted to the Director General for consideration. The post would also draw on existing Department of the Premier support and administrative staff.
2) Finalisation on which departmental management staff members will be formally assigned as lead agents in their respective departments by their Ministers and HODs, with the appropriate adjustment of their KPAs.
3) Re-appointment of the Western Cape Substance Abuse Forum will require nominated members from each department. It is recommended that the same staff indicated in points 1 and 2 sit on the substance abuse forum, with the co-ordinator chairing the forum.
4) The most substantial human resource implications are at operations level, in line with the overall government's focus on strengthening this aspect of the provincial administration. There are at least four main areas where extra operational staff need to be actively recruited (and also trained where the existing regional skills pool is not adequate to fill required posts):
    1. Needs analysis to be conducted for new social worker and social auxiliary worker staff in Department of Social Development facilities and programmes for Levels 1-4. As already mentioned, this can be addressed within the context of the broader Department's recruitment drive seeking to increase in-house capacity by 800 social workers and social auxiliary workers. It must be noted, however, that substance abuse related services are specialist services, and need a contingent of dedicated staff with the requisite skills.
    2. Needs analysis will indicate whether further psychiatrist and clinical psychologist staff will be necessary for Department of Health programmes for Level 3b (detox and inpatient treatment).
    3. Needs analysis to be conducted for new specialist social workers to boost existing probation officer contingent 70 personnel in the Department of Social Development.
    4. Skills and recruitment plan to be drawn up to increase number of social workers available to schools over the MTEF, from 49 school social workers to between 150 and

200 (an amount of at least R40 million and at most R100 million, to be sourced from the overall Provincial fiscus for this purpose, recruitment to occur in Department of Social Development. This is entirely subject to availability of suitably skilled professionals. Will also serve other priorities such as improved education outcomes (by providing support to principals and teachers struggling with learners that have behavioural problems) and other transversal projects like the Premier's Office on Youth and Women.

5. Various training interventions in specialised drug and alcohol harm reduction skills needed for existing staff.
6. Province can also benefit from extra capacity through social worker, psychologist and other multi-disciplinary student internships/learnerships.

Any personnel implications resulting out of the roll out of the programme will be dealt with in accordance with the provisions of the Labour Relations Act, 1995.

9. FINANCIAL IMPLICATIONS

The first year of implementation of this Strategy and Framework will not have major financial implications for the Provincial Government. The total increase in costs to the Province over the MTEF (excluding inflation adjustments) in the region of an additional R50 – R80 million required from the overall fiscus. In the first year and the MTEF funding on less productive projects (particularly outsourcing of services) can be transferred to cover more internally-driven projects (or more cost-effective outsourcing options), so avoiding the need for substantial extra costs over and above currently allocated funds for substance abuse-related projects. The main new items that have budgetary implications are:

1) Additional operational staff (as indicated in Section 7)
2) Costs of implementing and running new centralised information management system and regional information systems linked to facilities and programmes
3) Bursaries for skills development of potential recruits (beginning 2011 academic year)
4) Training programmes for existing staff
5) Funding for academic appointments in major universities to run post graduate specialised programmes in drug and alcohol harm prevention and treatment (beginning 2011 academic year)
6) Funding for research by universities and MRC.

There are also significant opportunities for external donor and private sector corporate social investment (CSI) funding to be harnessed to support items in the Strategy (to be facilitated in partnership with the newly formed Provincial Department of Strategic Partnerships), and a partnership is currently being negotiated with the United Nations Office on Drugs and Crime which could yield extra financial and specialised human resources support.

10. ANNEXURES (RELEVANT LEGISLATION AVAILABLE SEPERATELY)

Appendix – Summary and commentary on 'Tiers of Intervention' or Levels of service 1-4:

According to *WHO Clinical Guidelines for Withdrawal, Management and Treatment of Drug Dependence*: 2009 Sarah Larney; a 'tiered' or 'stepped' approach to drug and alcohol problems are the most effective because "This approach optimised the use of resources by reducing unnecessarily intensive treatment"

This approach offers levels of care that:

- Reflect increasing intensities of comprehensive services to provide a seamless continuum of care
- Match patients (including family members) to the least intensive intervention that is expected to be effective

- Can be 'stepped up' or 'stepped down' based on how the service user responds to the chosen intervention
- Aims to meet Service Users 'where they're at'.

Level 1: Information, Screening, Referral, Keywork

This is a community based service and provides the first point of contact for people seeking advice about drug and alcohol issues related to themselves, a family member, friend or colleague. The aim is to build a relationship and trust with the individual that will enable them to move towards appropriate treatment and other services.

Services include information and advice, screening for alcohol/drug misuse and referral to specialist alcohol/drug services, keyworking i.e. outreach to drug and alcohol users and their children and families.

Level 2: Information, Screening, Assessment, Brief Interventions, Care Management and Care Planning, Structured Day Programmes

This level of service covers triage/assessment, advice and information as well as a harm reduction focus given by specialist alcohol/drug treatment services – the Drug Assessment Team (DAT), comprising social development workers (City & Province), Health (City & Province) and other specialist service providers.

Level 2 is open-access specialist alcohol/drug drop-in services for drug users and their families. These services do not always need a care plan.

Level 3a: Specialised outpatient/non-residential alcohol and drug treatment

Drug/alcohol users and their families are referred to this level of service by the Drug Assessment Team (or can self refer) Non residential specialized treatment services can be built into the Drop In Services after the other services are up and running successfully or IOP (Intensive Outpatient)Non-residential treatment can be offered in stand-alone facilities and as part of other services. for example Cape Town Matrix clinics, Cape Town Drug Counselling Centre, Sultan Bahu, Kenilworth Clinic, Changes (Paarl) etc).This level of service always requires a care plan and specialized structured drug/alcohol programme rendered by qualified professionals. Clients in this level of care may require brief hospitalization for detoxification. A multi-disciplinary team is needed for this service.

Level 3b: In-patient treatment

In-patient treatment is indicated for individuals who require hospitalization or who cannot manage in an out-patient setting. (*Note: avoid mixing sentenced users and voluntary patients*)

Level 4: Aftercare and reintegration

Level 4 assists clients to reintegrate into the community and maintain the positive treatment gains they have made in Levels 2, 3a and 3b by providing planned support services for clients endeavouring to remain abstinent in Level 2 (described below) or after completing a residential or out-patient programme.

This level of service is provided and coordinated by the DAT and DIT, and involves government departments (local and provincial) such as DCS, DoSD, Health, etc. as well as other service providers within the community and community structures – housing, jobs, learnerships etc.

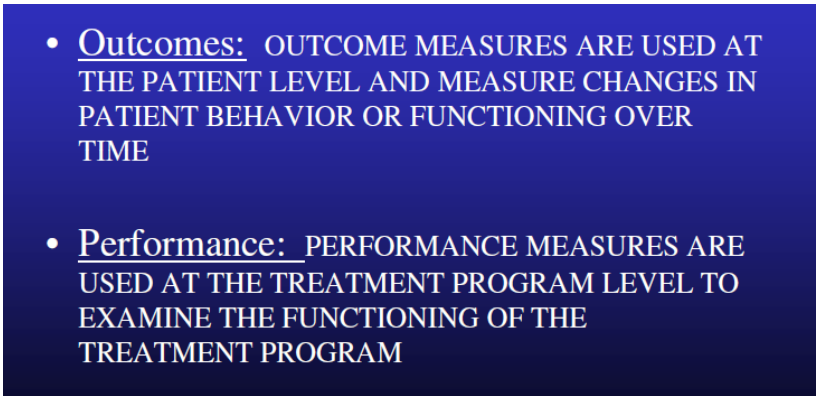
There are many facets to this level of service such as:

- Relapse Prevention and Early Recovery Skills – drop in groups as well as 'closed' psychotherapy groups and one-to one sessions;
- 12 Step Recover Groups
- Social Support Groups

- General Physical & Mental healthcare;
- Education, including parenting
- Skills Development;
- Job Creation;
- Sober Living Accommodation

(*Note: might also include outpatient programme), need services running at night as well, so might be good to use separate community centres rather than clinics (because need open for things like AA, and NA meetings – like Powerchild). Include Health as well – eg. Doctor coming twice a week, psychiatrist coming twice a week, etc. crèche for mothers who are abusers*).

Performance Management: What we should be measuring:



LIST OF ALL REGISTERED AND UNREGISTERED TREATMENT CENTRES KNOWN TO THE DEPARTMENT OF SOCIAL DEVELOPMENT

Table 1: List of all registered Treatment Centres

Name of Treatment Centre	Address	Registration Status	Conditions
De Novo Treatment Centre	Old Paarl Road Kraaifontein 021 988 1138 fax: 021 98804	State Owned	N/A
Kensington	Kensington road Maitland 7405 021 5119169	State Owned	N/A
Hesketh King	Elsenburg Klipheuwel and Old Paarl road Muldersvlei 7607 021 8844600	28 June 1993	Registered for 60 Male patients
Ramot Treatment Centre	54 Toner street Parow 7500 021 939 2033	29 January 2001	

	Fax: 021 9303123		
ToevlugTreatment Centre	40 Noble Street Riverview Worcester 023 342 1162	15 December 2005	
Crescent Clinic	269 Main Road Claremont 7708 021 762 7666	11 June 2001	
Horizons Halfway	House75 Ninth Avenue Schaapkraal Riedewaan Carelse Tel 021 737886	According to the Wynberg District office this centre moved from this address.	
Orient Rehabilitation	Centre C/o Boundary and Boom Street Schaapkraal 021 7042032 0829233057	16 August 2000	Registered for 60 male clients.
Stepping Stones	Main & Van Imhof Rds Kommetjie 021 783 4230 John Brock (CEO) Cnr.	1998	
Tabankulu Addiction Recovery Centre	1 Corsica Avenue Capri Village Fish Hoek 7975 Tel :021 785 4664 Fax :021 785 4665 tkulu@mweb.co.za	August 2000	
Claro Clinic	Ground Floor Burnside House Syfred Douglas Street N1 City Goodwood Tel 021 595 8500 Mr Rossouw	2001	
Serendipity House (half-way house)	6&8 Devonshire Rd Woodstock 021 448 9841 Steven Thomson	2004	
Tharagay House (half-way house) Gibson	15AGibson Road Kenilworth	2 August 2006	

	Tel 021 685 2657 Pam Goodman		
Kenilworth Place Addiction Treatment Centre	32 Kenilworth Rd Kenilworth Tel 021 685 2657 Dr Roger Meyer	September 2003	
Loyola Addiction Treatment Centre Fax: 088 021 785 4302 Mr. Anton Wessels	37 Lochiel Rd Capri Village 021 785 4302 Mr. Anton Wessels 082 574 4266	13 November 2007	
False Bay Therapeutic Community Centre	No. 1 2nd Avenue Fish Hoek 7975 021 – 7826242	10 July 2009	
Namaqua Treatment Centre no. 1	Centre no. 1 Farm 1411 Olifant Nedersetting Lutzville	28 September 2009	

Table 2: List of Treatment Centres awaiting zoning:

Name of Treatment Centre	Address	Action taken
Montrose Place _ Half Way House	**No 7 Montrose Terrace Bishopscourt, 7708 Debbie Tel: 021 797 9270**	Final assessment report completed.
Harmony House Addiction Treatment Centre	**20 Grandvue Road, Walmer Estate, Cape Town Stephen Thomas Tel: 021 448 8025 Fax 0866276221 082 703 6629 harmony@mystery.co.za**	Letter was send to the municipality on 12/2/2008 to attend to the zoning of this facility.
Victory Outreach Recovery Homes	**11 Naude Street Kuilsriver 021 903 7979 079 298 3453 James Kent Brady**	Facility has been moved to Milnerton.Awaits new application for registration.

Teen Challenge	**Tel: 021 843 3288** **Tel : 021 904 0555** **Cell:0721149926** **Fax 021 904 0088** **nomdoej@webmail.com** **Paster Nomdoe**	Centre has been zoned incorrectly. The manager re applied to be zoned correctly.
SANCA Western Cape Inpatient **treatment centre**	**32 Protea Street** **Durbanville** **David Fourie** **Tel: 021 945 4080** **Fax: 021 945 4082** **Cell: 082 852 1305** **Email:** david@sancawc.co.za	Centre is not operational. Awaits rezoning.
Namaqua Treatment Centre no2	**Park Street** **Vredendal**	Centre is not operational. Awaits rezoning.
Harmony Clinic (Addictions House)	**Valley Road** **Hout Bay** **Tel: 021 4488025** **Fax :0866959067** **Emergency Number** **:0827036629**	Letter was send to the municipality on 1/12/2008 to attend to the zoning of this facility.

Table 3: List of Treatment Centres closed

Name of Treatment centre	Address	Current Situation
Lighthouse Therapeutic Community*	**120 Retreat Road** **Retreat** **Gassieb Jacobs** **Tel: 021 712 9357** **Cell: 083 414 0548** **Fax:021 712 93 57** **Gaseeb @ telkomsa.net**	This Treatment Centre closed and reapplied for registration.
Al- falalaqa T/Center	**13th Avenue** **Schaapkraal** **7945** **Faizal 0738419135** **Tel: 021 396 5991** **Fax: 0866898734**	This Centre allegedly is still operational

Ragma for Girls and Boys Treatment Centre	**18 Hide Road, Fairways, Parkwood Gadija Mobara Fax.no. 0217056162 Tel: 021 7056162 Sayed Davids 0838562601**	This centre allegedly is still operational
De Hoop Tertiary Care	**25 Vigne Street** Greyton	This treatment centre has been requested to apply for registration. No application received. A letter of closure has been sent.
.Ragma for Girls and Boys Treatment Centre	**18 Hide Road, Fairways, Parkwood Gadija Mobara Fax.no. 0217056162 Tel: 021 7056162 Sayed Davids 0838562601**	This centre allegedly is still operational.
HOW Rehabilitation Centre	**30 De Beer street Strand** **Shamiel Davids Tel ;021 853 5748 Fax: 021 853 5748 0742108297**	This centre closed down. Has reopened as Western Cape Therapeutic Community Centre
Hope Again Recovery Home	**Cnr Ajax & Artemis Street, Woodlands, Mitchell's Plain**	This centre closed down.
Circle of Friends	**Post Office Building Victoria Road Grassy Park**	This centre closed down.

TREATMENT FOR CO-MORBID PATIENTS

LICENSED PRIVATE MENTAL HEALTH BEDS IN THE WESTERN CAPE - 2010								
District	**Health Sub-district**	**Name**	**City / Suburb**	**Psychiatry - Voluntary Users**				**Dept of Social Develop-ment**
				Over 18	Between 12 and 18	**Under 12**	**Total beds at facility**	**Substance Abuse Beds**
Cape Town	Tygerberg	Claro Clinic	Goodwood	24			**24**	21
		Tiger Clinic	Loevenstein	17	4		**21**	
			Sub-Total	41	4	**0**	**45**	**21**
Cape Town	Eastern	Strand Medi-Clinic	Strand	10			**10**	
			Sub-Total	10	0	**0**	**10**	**0**
Cape Town	Southern	Crescent Clinic	Kenilworth	40			**40**	30
		Kenilworth Clinic	Kenilworth	36			**36**	24
		Stepping Stones Centre	Kommetjie	30			**30**	5
			Sub-Total	106	0	**0**	**106**	**59**
Cape Town	Western	Cape Town Medi-Clinic	Cape Town	10			**10**	
			Sub-Total	10	0	**0**	**10**	**0**
Cape Town	Mitchell's Plain	Melomed Mitchell's Plain	Mitchell's Plain	18			**18**	
			Sub-Total	18	0	**0**	**18**	**0**
Cape Town	Klipfontein			0			**0**	
			Sub-Total	0	0	**0**	**0**	**0**
Cape Winelands	Breede Valley / Worcester	Pines Clinic	Worcester	24			**24**	
			Sub-Total	24	0	**0**	**24**	**0**
Overberg	Overstrand			0			**0**	
			Sub-Total	0	0	**0**	**0**	**0**
Eden	George	George Neuro Clinic	George	40			**40**	
			Sub-Total	40	0	**0**	**40**	**0**
Cape Winelands	Drakenstein	Sereno Clinic	Paarl	16			**16**	
			Sub-Total	16	0	**0**	**16**	**0**

NB: Shaded areas include patients over and under 18 years of age.			Total beds	241	4	**0**	**269**	**80**

11. GLOSSARY AND ACRONYMS

Brief Intervention – See first appendix item for explanation of this term

DOH – Department of Health (applies to the Western Cape Provincial Department in this document unless otherwise indicated)

DOSD – Department of Social Development (applies to the Western Cape Provincial Department in this document unless otherwise indicated)

In-patient and Outpatient Treatment – See first appendix item for explanation of these terms

PGWC – Provincial Government of the Western Cape

LDAC – Local Drug Action Committee – as defined in the National Drug Master Plan 2006-2011 and the Prevention of and Treatment for Substance Abuse Act 2008

Service Levels 1-4 – Refer to first appendix item for explanation of Levels 1-4

WCSAF - Western Cape Substance Abuse Forum – refers to Provincial Substance Abuse Forum as defined in the National Drug Master Plan 2006-2011 and the Prevention of and Treatment for Substance Abuse Act 2008